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Philadelphia College of Osteopathic Medicine

Department of Psychology

AFRICAN AMERICAN PENTECOSTAL CLERGY MEMBERS' PERCEPTIONS OF MENTAL HEALTH AND THEIR SUBSEQUENT REFERRAL PRACTICES

By Jasmine Harris

Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Psychology

May 2018

PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE
DEPARTMENT OF PSYCHOLOGY

Dissertation Approval

This is to certify that the thesis presented to us by _____

on the _____ day of _____, 20___, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

Committee Members' Signatures:

_____, Chairperson

_____

_____

_____, Chair, Department of Psychology

Dedication and Acknowledgements

First, I would like to give praise and glory to Jesus Christ my Lord and Savior, who receives all of the honor for allowing me to make it this far. Thank you for your grace, mercy, and favor bestowed upon me, which has equipped me to excel and persevere to the end; great is thy faithfulness!

To my beloved mother and father: Without your unconditional love, support, and prayers my dreams would not have been realized. I am forever indebted and grateful for all of the sacrifices, all of the tears you have shed, and all of the time that you have invested in my growth and development both spiritually and academically. Thank you for accompanying me on this journey, holding my hand, wiping away my tears, and encouraging me to finish this race. Your investment, love, and sacrifices made into my life are not in vain; I loved you yesterday, I love you today, and I will cherish you forever.

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Finally, I would like to dedicate this work to my grandmother, who is smiling down on me from a front row seat in Heaven! Joan E. Douglas, the epitome of strength, you have left me here on Earth, but your strength has manifested itself in me. I know you are shouting in Heaven, and announcing to the angels, that your granddaughter is a doctor. Thank you for your infinite love, wisdom, support, and sacrifice shown towards me through all of my endeavors. I will hold you forever in my heart until I can hold you again in Heaven.

Philippians 4:16 "I can do all things through Christ who gives me strength."
Proverbs 3:5-6 "Trust in the Lord with all thine heart, lean not to thine own understanding, in all thy ways acknowledge Him, and he will direct thy paths."

Abstract

African Americans do not seek or receive mental health services as much as their Caucasian counterparts. There is a myriad of factors that influence the reasons why many African Americans are not seeking services, including, stigma, mistrust, affordability, accessibility, and availability of services. Because of these factors, many African Americans tend to seek psychological help from their religious advisors. Pentecostal Christians' religious views may directly conflict with seeking services from a mental health professional. This study's aim was to explore African American clergy members' perceptions of mental health and to determine how those perceptions influence their subsequent referral practices to mental health professionals. A sample of 13 Pentecostal clergy members were interviewed individually and reported various views of mental illness, which included their perceptions of mental health and illness and the perceived etiology of mental illness. Factors such as clergy members' levels of education, conservative or liberal views, and religious beliefs about mental illness may influence whether they refer parishioners to secular mental health services.

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Chapter 1: Introduction

Statement of the Problem

As humans, we have a natural inclination toward spirituality. Our ancestors have viewed many facets of life through a spiritual lens. In fact, humans, nature, and the environment were all viewed as part of the spiritual process (Bohm, 1991). Through the development of civilization, previously held views of spirituality, including a bidirectional relationship between nature and humans, was gradually replaced with organized religion (Bohm, 1991). No longer was there a primary focus on finding spirituality throughout everything; instead, there was a focus on philosophical knowledge and how that knowledge pertained to the overall worldview of the time (Bohm, 1991).

Psychology is derived from the Greek word "psyche," meaning "soul," which is a central component of most Christian religions (Sullivan et al., 2014). "Psyche," which is a term essential to both psychology and religion, infers that, fundamentally, both offer a foundation for describing human behavior and experience, and that their goals and methodologies may converge. Despite this commonality in vocabulary, the relationship between psychology and religion has been contentious and antagonistic at worst and one of "mutual ignorance" at best (Sullivan et al., 2014).

Prior to the Enlightenment era, these concepts were synonymous; illness was best understood from a spiritual framework until the Age of Reason (Sullivan et al., 2014). Then emerged the rise of science, and with it came biomedical explanations for illness and human behavior, which contributed to the tension that eventually rose between the church and science (Sullivan et al., 2014). Assumptions of the biomedical model view illness as an imbalance within psychological and physiological processes. It posits that

there is a bidirectional relationship between psychological and biological processes that affect health outcomes (Biosocial and Biomedical Model of Health, n.d.). This biomedical model suggests that diseases are caused by biological agents (i.e., germs) by trauma or biological disruptions in one's cellular or molecular structure (Biosocial and Biomedical Model of Health, n.d.). Illnesses that are not somatic are unexplainable scientifically and are, therefore, viewed as unreal (Biosocial and Biomedical Model of Health, n.d.). The biomedical perspective views the patient as an organism, with a body that needs repairing. As such, the sole way to restore health is through scientific and medical procedures (Biosocial and Biomedical Model of Health, n.d.).

Scriptural evidence was used to support spiritual explanations of illness and human behavior. An account in the New Testament of Jesus casting out demons from a possessed man has often been posited as evidence for those in the Christian faith who believe that demonic possession or sin causes emotional and psychiatric conditions (Sullivan et al., 2014). From this understanding, prayer, exorcism, and repentance are often viewed as spiritual approaches to healing (Sullivan et al., 2014).

As such, the debate between religion and psychology continues. Mental health providers may view religion as additional content for psychotic patients, whereas parishioners may use religion as a coping mechanism or frame of reference for explaining their mental illnesses (Sullivan et al., 2014). At times, mental health treatment recommendations and religious preferences and beliefs may conflict with one another, leaving the patient-parishioner confused about which treatment to fully adhere (Sullivan et al., 2014). Conversely, mental health providers may directly or indirectly ignore or minimize the impact of religion on patients' lives, failing to acknowledge their spiritual

beliefs and practices, thereby choosing not to include it in treatment (Sullivan et al., 2014). Failing to acknowledge religious beliefs of the patient can devalue and underestimate religion as a source of support, but can also be viewed as cultural incompetence (Sullivan et al., 2014). Conversely, spirituality, if accepted and understood, can be viewed as integral, much like the biomedical model, in the treatment and understanding of mental illness (Sullivan et al., 2014). To improve treatment adherence for patient-parishioners, focus should be on both decreasing conflict and increasing collaboration between psychology and religion, so patient-parishioners can access both spiritual and mental health treatment (Sullivan et al., 2014).

Six considerations are present in the secular and religious literature that expand upon the need for collaboration between these two disciplines. First, clergy members, as gatekeepers, are often encountered first by mentally ill parishioners (Stanford & Philpott, 2011). Second, there is a need for increased education and knowledge about the differing values of both clergy members and mental health professionals (Stanford & Philpott, 2011). Historically, psychology and religion have different value systems and views on mental illness (Leavey, Rondon, & McBride, 2011). Depression is one of the most frequently described mental health concerns by clergy members; however, very rarely is the word depression actually used. Instead, clergy members often will use words such as "mentally deranged, of unsound mind, having a chemical imbalance, not in their right mind, or having a nervous breakdown" (Leavey et al., 2011, p. 68). The clinician must be skilled in knowing how the language chosen is being used to describe depression as a phenomenon. There is also a discrepancy between how adequately trained clergy members believe they are and how often they refer their parishioners to mental health

services (Stanford & Philpott, 2011). This suggests that clergy members who do not feel adequately trained in mental health and mental illness may be less likely to refer their parishioners to mental health services. This discrepancy is most apparent when clergy members believe they are ill-equipped and uninformed about the causes and available treatments of mental illnesses (Stanford & Philpott, 2011). As a result of these previous findings, increased education is not only necessary for clergy members, but for mental health professionals as well.

Third, there are obstacles that may interfere with the two disciplines collaborating (Stanford & Philpott, 2011). Some obstacles include mistrust, misunderstanding, and lack of interest in collaboration from both clergy and mental health providers. These feelings of misunderstanding and lack of interest are experienced by professionals on both sides, whereas the feelings of mistrust are experienced primarily by religious leaders. Therefore, it is important to identify these obstacles and problem-solve around them when they occur. The fourth consideration is emphasizing how important shared values are in increasing collaboration (Stanford & Philpott, 2011). Despite the fact that religion and psychology appear to have different core values, some values and beliefs are shared. In order to bridge the gap between the two fields, minimizing the differences and emphasizing the similarities will make connection and collaboration between the two fields possible. The fifth is highlighting the benefits of collaborating (Stanford & Philpott, 2011). For mental health providers, treatment approaches have increased effectiveness when patients are viewed from a biopsychosocial-spiritual perspective, in that they understand and acknowledge that there are many contributing factors that influence a patient's overall health. The benefits of collaboration become more salient

when clinicians and clergy can recognize how multiple factors can be interrelated to the psychological and spiritual health of individuals (Stanford & Philpott, 2011). Finally, clergy play an integral role in the identification and prevention of mental illness from developing or increasing in chronicity and severity within the African American community (Stanford & Philpott, 2011). As research suggests, patient-parishioners first seek help from their clergy members. Therefore, if clergy members could identify potential mental health consumers sooner, patient-parishioners could receive services earlier, minimizing the chances of exacerbating their symptoms (Stanford & Philpott, 2011).

Chapter 2: Literature Review

Approximately 13% of the United States population identify as African Americans, equating to approximately 34 million people (Carr-Copeland, 2005; Dana, 2002). African Americans make up an ethnic minority that has been underserved historically, and serviced ineffectively by mental health professionals (Meyer & Zane, 2013). Despite their population size, African Americans experience disparities in the occurrence, pervasiveness, and mortality rates of mental health conditions when compared to European Americans (Carr-Copeland, 2005). When compared with European Americans, African Americans who suffer from mental disorders or substance use problems are less likely to receive mental health treatment (Carr-Copeland, 2005). Moreover, those who suffer from comorbid disorders are even less likely to seek mental health treatment due to the severity of their symptom presentations (Cheng & Robinson, 2013). Additionally, African American men use mental health services less often than their female counterparts (Smith, 2002). Since men are socialized to view themselves as strong, this may directly influence their ability to seek help (Smith, 2002). Even when they seek treatment, men are often concerned about appearing weak; therefore, they restrict their emotions by limiting what they disclose to mental health professionals (Smith, 2002).

Approximately 60% of African Americans diagnosed with mental health conditions do not receive mental health treatment (M. P. Davey & Watson, 2008; Hall & Sandberg, 2012). Of those that do, they are typically overrepresented in inpatient treatment facilities and underrepresented in outpatient services due to delays in seeking treatment (M. P. Davey & Watson, 2008; Hall & Sandberg, 2012). African Americans are at an

increased risk for being committed involuntarily, which may also reinforce the fear and mistrust that they have of mental health professionals (Lindsey, Chambers, Pohle, Beall, & Lucksted, 2013). This help-seeking pattern may indicate a crisis-oriented style of seeking services, suggesting that African Americans are more likely to seek services under dire and crisis situations (Snowden, 1999).

There is a myriad of factors explaining why African Americans typically do not seek treatment when necessary. One reason is attributed to the stigma that is associated with mental illness. African Americans may not engage in treatment due to their fear of being ostracized from their community (M. P. Davey & Watson, 2008). Furthermore, there can be a sense of mistrust that African Americans will be misdiagnosed, over-diagnosed, or misunderstood because of the possible cultural differences between African American patients and their therapists (M. P. Davey & Watson, 2008). Finally, affordability, accessibility, and availability of services all influence African Americans' utilization of services (M. P. Davey & Watson, 2008). Mental health services tend to be expensive if not covered by insurance, and even when services are covered, outpatient clinics are not always located conveniently within African American communities (Hall & Sandberg, 2012). The differences that exist with the perceived need for treatment and the previous experiences of treatment contribute to the delay and underutilization of mental health services (Cai & Robst, 2016). Further, when African Americans seek help through mental health services, the quality of such services may be substandard or received too late (Allen, M. P. Davey, & A. Davey, 2010; M. P. Davey & Watson, 2008).

Given that many African Americans are reluctant to seek mental health services outside of the community, they tend to rely on the support of their families and religious

leaders, so the church becomes a likely place to go for counseling (Lindsey et al., 2013). The church has been a consistent and dependable source of support for many African Americans for centuries (Adksion-Bradley, Johnson, Lipford-Sanders, Duncan, & Holcomb-McCoy, 2005). The creation of the "Black Church" was a result of the religious oppression that African Americans experienced during the time of slavery. Institutionalized Black religion developed within the hostile racial climate that existed during the antebellum era. It doubly served as a safe haven and allowed African Americans the opportunity to worship freely. Since the end of slavery, the Black Church has played a pivotal role in the preservation of the culture of African Americans. It has been an outlet that has allowed members of its community to survive during volatile and harsh times.

This reliance on the Black Church continues and is evident in the literature. It has been reported that approximately 40% of African Americans use clergy members as their primary resource for mental health treatment, and that they are 2.5 times more likely to seek help from a clergy member than a mental health professional (Anthony, Johnson, & Schafer, 2015). Through the Church, clergy provide emotional and spiritual counseling to congregants in an effort to "heal" their mental suffering. Congregants tend to go to their clergy for counseling on religious development, grief and bereavement, health and financial concerns, and familial discord (Shephard Payne, 2008). Still, there are some topics that are not addressed comfortably by clergy members, such as sexual violence, domestic violence, and substance use concerns (Shephard Payne, 2008). Since African Americans often go to the Church for emotional support, mental health professionals and clergy are likely to encounter similar presentations and severities of psychiatric

conditions (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000); however, clergy tend to underestimate the severity of symptoms and are not usually trained in identifying chronic and severe cases. African American pastors tend to believe that a lack of trust in God can lead to depression, whereas Caucasian pastors more likely believe that depression is biological in nature (Hedman, 2014). Likewise, Pentecostal clergy at times believe that depression is caused by a moral or spiritual flaw, whereas other Protestant clergy believe that the etiology of depression stems from a medical or biological basis (Hedman, 2014).

Taylor et al. (2000) found that only 10% of clergy refer their congregants to mental health professionals despite their inability to effectively treat more severe cases. Of those 10%, those who are more likely to refer to mental health professionals include those with advanced degrees and with liberal perspectives (Taylor et al., 2000). Conversely, those with less secular education and more conservative theologies are more likely to attempt to solve the psychiatric problem through "faith healing" in the Church, which may not fully address more severe symptomatology (Taylor et al., 2000). More often, clergy believe that they lack training and expertise in appropriate mental health diagnoses and treatment approaches (Hedman, 2014). Congregants who receive counseling from their clergy are less likely to seek additional mental health treatment, especially from outside agencies that are viewed as secular by the Church. The focus of the current study was on Pentecostal clergy members and the perceived impact that their specific beliefs may have on their referral practices. The tenets in Pentecostalism emphasize healing by God and the cause of illness resulting from religious flaws. As a result, this study endeavored to explore how Pentecostal clergy members' mental illness perceptions may influence their subsequent referral practices.

Relevant Theory

Social psychology theories may help explain and clarify the help-seeking style used within the African American community. Relevant theories include stigma theory; in-group and out-group biases, particularly deviance and ostracism; and implicit and explicit attitudes and the impact those attitudes have on behaviors and value judgments.

Stigma theory posits that there are two forms of stigma associated with mental illness: public and internalized stigma (Conner et al., 2010). Public stigma is defined as the "negative beliefs, attitudes, and conceptions about mental illness held by the general population which lead to stereotyping, prejudice, and discrimination against individuals with mental health disorders" (Conner et al., 2010, p. 533). Conversely, internalized stigma refers to "the devaluation, shame, secrecy, and social withdrawal, which are triggered by applying the negative stereotypes associated with mental illness to oneself" (Conner et al., 2010, p. 533). There is a social stigma and cultural taboo that is associated with seeking mental health services within the African American community (Hall & Sandberg, 2012). Conner et al. (2010) described an inverse relationship between stigma and help seeking. This results in feelings of shame, self-stigma, and public stigma about receiving mental health treatment, making it more difficult for African Americans to seek services (Goguen et al., 2016). In addition to the stigma that exists, those who perceive discrimination within the mental health care system are more likely to delay seeking treatment (Cai & Robst, 2016).

The second theory posits that groups are inherently exclusionary, there are often expected standards and norms that are endorsed, and if one does not ascribe to those standards, punishment or ostracism is warranted (Hutchison, Jetten, & Gutierrez, 2011).

Deviance is defined as departing from one's group norms or values, in which one behaves in an atypical or unusual manner by failing to conform to group standards and norms (Hutchison et al., 2011). Groups exert pressure on group members to maintain conformity for multiple reasons. First, members receive a reinforced sense of validation by others who share similar views and perspectives. Second, in order to achieve vital group goals, the group members must agree (Hutchison et al., 2011). When a deviant member is identified, increased attention is directed toward that member in an effort to regain conformity, in order to avoid rejection (Hutchison et al., 2011). Similarly, African Americans seeking help from mental health professionals can be viewed as taboo, deviating from the cultural norms and standards of their group and community. As a member of a Pentecostal congregation, a person may be discouraged from seeking help from mental health providers, as it could be viewed as the individual is lacking in faith. Generally, mental illness often carries a stigma in this community that affects treatment engagement, as individuals fear being ostracized from their community (M. P. Davey & Watson, 2008). Seeking help from mental health professionals can lead to African Americans feeling ostracized. In order to increase conformity, receiving help from a religious advisor may be more strongly encouraged, as spiritual counseling is less stigmatizing, expected and accepted, adheres to the spiritual assumptions of mental illness etiology, does not reflect poorly on the community, and keeps cultural and community information private. If a parishioner is interested in receiving services, he or she may have to meet with the pastor or clergy member of the Church, set up an appointment or consultation, and then be referred to see the spiritual advisor that is most appropriate.

The final theory emphasizes attitudes and their role in informing values, which determine behaviors. Attitudes, in fact, are an expression of one's values. Attitudes can be viewed as a negative or a positive evaluation, and that evaluation exerts an influence on one's responses. Strong negative attitudes toward mental health have increased the stigma that exists with receiving mental health services. Implicit attitudes are those positive and negative attributions or feelings that one may have that exist outside of one's consciousness (Goguen et al., 2016). These implicit attitudes represent automatic beliefs, whereas explicit attitudes are a more conscious process (Monteith & Pettit, 2011). Implicit measures attempt to understand and predict behaviors that are deemed subconscious, uncontrollable, or automatic. Conversely, explicit measures attempt to predict one's controlled behaviors (Monteith & Pettit, 2011). Research suggests that negative attitudes individuals may have toward mental health treatment have a significant impact on their help-seeking behaviors (Conner et al., 2010). Those "who endorse more negative attitudes are five times less likely to seek mental health services than those with more positive attitudes (Conner et al., 2010, p. 531). Overall, research has shown that African Americans hold more negative attitudes toward mental health treatment in comparison to their White counterparts (Conner et al., 2010).

A recent study measured the implicit and explicit biases associated with mental health treatment and its perceived level of effectiveness (Goguen et al., 2016). Those who implicitly endorsed the attitude that mental health treatment was less effective also thought that mental health treatment was not good (Goguen et al., 2016). In comparison to medical treatment, mental health treatment was more likely to be rated implicitly as less effective and as less good (Goguen et al., 2016). This suggests that African

Americans who hold negative implicit attitudes about mental health treatment and its effectiveness are less likely to receive treatment and less likely to view the treatment as effective. In contrast, those who had received mental health treatment within the past year endorsed less negative biases toward receiving mental health treatment, suggesting that African Americans who have had personal experience with mental illness may have more positive implicit attitudes about mental health treatment, thereby increasing the likelihood that they would seek services.

These studies highlight and inform African American's help-seeking behaviors. The combination of public and internalized stigma, deviance and conformity, and implicit and explicit attitudes and biases about mental health are all factors that influence one's desire to seek services and further influence feelings of distrust and resistance to mental health treatment.

Factors Presenting as Barriers to Treatment

The mental health of African Americans is impacted by social and physical health factors present within their communities (Avent, Cashwell, & Brown-Jeffy, 2015). Approximately 16% of African Americans diagnosed with a mood disorder and 12.6% of African Americans diagnosed with an anxiety disorder seek treatment through mental health providers (Avent et al., 2015). These numbers are alarming. Research suggests that African Americans typically seek mental health services only when their mental health concerns have progressed to an acute state. As a result, it is important to explore any barriers that affect their ability to seek and receive mental health services. Barriers that may negatively impact African Americans' ability to effectively seek treatment and have been identified in the literature include historical factors, cultural factors (i.e., denial

of symptomatology and lack of culturally sensitive therapists), affordability, accessibility and availability of services, and spiritual factors (Avent et al., 2015; Hall & Sandberg, 2012).

Historical factors. For centuries, African Americans have been over-diagnosed, misdiagnosed, used as test subjects, and provided misinformation from both the medical and psychiatric communities. Harmful experiments were conducted and deleterious medical and psychiatric practices were employed, all producing unfavorable results concerning Black slave research subjects. Those unfavorable results concluded that African Americans were inferior or a "lower order of human beings" and that there was an ethno-genetic vulnerability that explained their inferiority (Suite, La Bril, Primm, & Harrison-Ross, 2007, p. 880). In the South, "night-doctors" would steal and dissect the bodies of deceased African Americans (Suite et al., 2007). Physician Thomas Hamilton wanted to create a medical treatment to counter the physical effects of a heat stroke. In an effort to find this treatment, he placed his male slave in a pit for several days, providing him with different medical mixtures to ingest in hopes of finding a cure. After each concoction was ingested, his slave would faint; Dr. Hamilton would revive him, to resume his experiments (Suite et al., 2007).

Medical acts of violence included the "Mississippi Appendectomy," in which physicians would sterilize hospitalized African American women without their permission; this continued into the 1970s (Suite et al., 2007). Most infamous are the Tuskegee Syphilis experiments that began in 1932. Governmental scientists conducted a study to determine the effects of syphilis, but their chosen subjects were Alabaman African American men (Suite et al., 2007). These scientists injected African American

men with syphilis and, although an antibiotic treatment was developed in the 1940s, they did not provide the treatment in an attempt to allow the disease to run its course to understand its effects (Suite et al., 2007). This experiment lasted for over 40 years and resulted in fatalities (Suite et al., 2007). This identifiable pattern of instrumental violence to African Americans recognizably increases feelings of mistrust and decreases the level of service engagement, which places a greater emphasis on alternative methods of care (Lowe, 2006).

Unfortunately, the use, misuse, and abuse of African Americans within research was not specific to medicine, but crossed the psychiatric barrier as well. In the 1800s, the primary diagnostic syndromes were melancholy, mania, dementia, and idiocy (Lowe, 2006). In 1840, the United States Census purposefully misstated the "insanity" rates of African Americans in an attempt to demonstrate that African Americans, who lived further south, had increased rates of mental illness (Suite et al., 2007). Many of the diagnoses that African Americans received were associated with the institution of slavery. For example, Samuel Cartwright coined the terms "drapetomania" and "dysaethesia aethiopica," which were ascribed only to slaves of that time (Lowe, 2006). Drapetomania was defined as "sulky and dissatisfied" behaviors that led slaves to flee (Lowe, 2006, p. 31). The latter diagnosis referred to a pattern of intentionally destructing one's property and paying poor attention to one's work, directly affecting the level of productivity. As mentioned, both of these terms were used exclusively for African Americans of that time and were bound to the culture and institution of slavery and racism (Lowe, 2006). This identifiable patter of instrumental violence to African Americans recognizably increases feelings of mistrust and decreases the level of service

engagement, placing a greater emphasis on alternative methods of care (Lowe, 2006). Additionally, the disparate use of diagnoses to pathologize the behavior of African Americans increases the stigma and mistrust ingrained within the African American population. Not only were African Americans test subjects, but their behaviors were viewed as pathological in an effort to preserve the institution of slavery.

Cultural factors. African Americans may distrust treatment providers and fear being labeled, misdiagnosed, and over-diagnosed (M. P. Davey & Watson, 2008). In fact, research has shown a positive relationship between racial biases and over-diagnosis of serious mental illness and under-diagnosis of less serious mental disorders (Suite et al., 2007). Within the African American community specifically, studies conducted since the 1970s have reported an over-diagnosis of schizophrenia, whereas affective disorders are less frequently diagnosed (Suite et al., 2007). Three explanations are given to understand this phenomenon: clinician prejudice, racial bias, and "contextual diagnostic analysis" (Suite et al., 2007, p. 882). Contextual diagnostic analysis posits that clinicians may be more likely to mistake an individual's religion, spiritual beliefs, and cultural distrust as disordered, or use such beliefs to diagnose a mental illness (Suite et al, 2007). This can lead African Americans to feel misunderstood, and less likely to seek professional help if their cultural and spiritual beliefs are fundamentally viewed as symptoms of a disorder. This phenomenon may increase the likelihood that African Americans are admitted at higher rates in inpatient hospitals than other ethnicities (Suite et al., 2007).

Ethnic and racial identities are addressed rarely in treatment contexts, a practice that may often leave patients of color feeling less satisfied with services. This lack of consideration of how individuals' identities may inform treatment also presents as a

barrier to seeking and receiving services. As a result, it is important that therapists and mental health professionals demonstrate cultural competence when working with individuals from different racial and ethnic backgrounds. Cultural competence includes understanding the importance of not only social but also cultural influences on patients' behaviors, beliefs, and notions of mental health and illness. Suite et al. (2007) coined the term "history-sensitive" to describe an approach of exploring how patients understand and interpret their cultural histories, and how that understanding could influence their treatment outcomes and experiences (Suite et al., 2007). Not only can a history-sensitive approach reduce cultural mistrust, it may also increase utilization of services, thereby fostering a reduction in mortality and chronicity rates (Suite et al., 2007). Clinicians operating from this approach are encouraged to explore the complexities and uniqueness of their own histories as well (Suite et al., 2007).

Just as culture, race, and ethnicity are constructs that are typically under-attended to during the therapeutic process, religion and spirituality also receive limited focus in the therapeutic relationship. As a result of feeling misunderstood and being misdiagnosed and falsely labeled, spiritual advisors have served as resources to address the mental health needs of their parishioners. Spiritual advisors have often been viewed as an extension of, or informal member of, the mental health network (Crosby & Bossley, 2012). The religiosity gap explains that some clients who endorse religious beliefs may feel disconnected during treatment (Crosby & Bossley, 2012). These religious gaps may create barriers and strain the therapeutic relationship if not addressed, which may decrease the likelihood of continuing to seek help outside of the Church (Crosby & Bossley, 2012). There are various explanations about why a religious client may seek

help from a religious advisor before seeking help from a mental health professional. First, the client may feel less likely to censor any religious beliefs that are fundamental to his or her religious identity (Crosby & Bossley, 2012). Second, some believe that seeking services from mental health professionals with whom they do not share similar religious values may threaten their faith (Crosby & Bossley, 2012). Lastly, the client may believe the therapist is not attuned to the "language" and the culture of his or her religion, and may have difficultly connecting and building rapport (Crosby & Bossley, 2012; Stanford & Philpott, 2011).

The cultural responsiveness hypothesis posits that psychotherapy becomes effective when the treatment provider is able to process and understand the cultural background of the patients being treated (Blank, Mahmood, Fox, & Guterbock, 2002). Additionally, racial matching has been associated with increased utilization, lower dropout rates, and greater treatment satisfaction (Meyer & Zane, 2013). Meyer and Zane (2013) emphasized the importance of open communication about cultural identities in the therapeutic dyad, as these conversations can advance and foster a safe treatment environment. Patients acknowledge that therapeutic relationships with providers directly influences their satisfaction, treatment adherence, and overall treatment outcomes (Carr-Copeland, 2005). Research suggests Caucasian mental health professionals may be limited in their ability to fully understand the history and experiences of African Americans in a largely White society (Blank et al., 2002).

There is a myriad of cultural factors that impact and may present as barriers to African Americans receiving treatment. Ignoring existent cultural and racial factors between patients and providers negatively influence patients' mental health treatment

experiences (Carr-Copeland, 2005). Providing culturally responsive, sensitive, and competent treatment can help reduce the mental health disparities that exist within minority communities (Meyer & Zane, 2013). Respecting and understanding the importance of race, culture, and ethnicity are vital aspects of understanding and treating African American patients that may present for treatment (Moodley, 2005).

Affordability, accessibility, and availability of services. Currently, approximately 25% of African Americans are living in poverty, and 20% are uninsured (Cheng & Robinson, 2013). These statistics suggest that there are financial stressors that may negatively influence the accessibility and quality of treatment this population receives (Cheng & Robinson, 2013). Not only may services be too expensive, but they also tend to be inaccessible for the African American population (M. Davey & Watson, 2008). Mental health services can be expensive if insurance carriers do not cover costs, and outpatient clinics are not always located conveniently in predominately African American populated neighborhoods. This increases the inaccessible nature of services and decreases the likelihood that African Americans will seek services.

In order to effectively, efficiently, and speedily service and reach a community that under-utilizes mental health services, clinicians are presented with a few responsibilities to help facilitate culturally sensitive treatment efforts (Suite et al., 2007). Clinicians must fully examine their own implicit and explicit biases and attitudes about race and the history of racism in the United States, including its impact on persons of color (Suite et al., 2007). Clinicians should acknowledge that African Americans represent a community of people, but also demonstrate willingness to explore the nuances that exist within this seemingly homogenous population, understanding the patients within their

sociocultural, religious, political, and historical contexts, and how these factors influence their identities individually and within their communities (Suite et al., 2007).

Spiritual factors. Both mental health providers and clergy are likely to encounter the same types of clients in reference to the categories of disorder and the severity of their presentations (Taylor et al., 2000). Nevertheless, clergy are more likely to underestimate the severity of psychotic symptoms and are less likely to recognize suicidality (Taylor et al., 2000). Despite their inability to effectively assess for these presentations, it was found that only 10% of clergy members refer congregants to mental health professionals (Taylor et al., 2000). What makes these numbers even more alarming is that less than half of African American clergy have training in clinical pastoral counseling, so they may encounter individuals with mental health presentations and may not know how to address their needs and concerns fully (Anthony et al., 2015).

There is a fine line between what one would define as a "religious experience" and what others may view as psychosis; the distinction between that line could influence whether someone presents to mental health treatment. If the clergy member views the experience as spiritual, then he or she may be less likely to refer to mental health services; however, if there is a distinction made between the religious experience that categorizes it as psychosis, he or she may be more likely to refer to mental health providers. A study conducted by DeHoff (2015) looked specifically at these two constructs within Presbyterian clergy. Hearing the voice of God or seeing Jesus the Christ may be viewed as religious experiences, psychotic experiences, or both depending upon the religious and/or mental health professional interpreting the experience. The content and context of what is reported to the mental health professional or religious

advisor can delineate between a psychotic experience and a religious one (DeHoff, 2015). Prior to making the determination of the experience, it is vital to consider the client's culture and background because these may contribute and explain the client's experience. The clergy members in this study all endorsed that they have been exposed to psychosis within their ministries; however, 85% of those clergy members also reported that they have never received formal training in ways to identify the difference between the two.

Internal and external experiences of God. Within the DeHoff (2015) study, 70% of the clergy members reported that they have interpreted internal experiences of God as feeling his "inner presence" or inner peace. They identified these experiences as being most present during prayer, while dreaming, hearing God's voice in the inner-man (internally), through Scriptures, and feeling led by God (DeHoff, 2015). The external experience of God specifically involved the activation of one's senses, through sight, sound, and touch (DeHoff, 2015). Approximately 70% of the participants also endorsed that they experienced external experiences of God, including seeing a bright light, seeing Jesus, feeling God's healing power, and hearing God's voice (DeHoff, 2015).

Criteria were suggested by the clergy members to determine what is deemed spiritual, what is deemed psychotic, and what is deemed both: The clergy members identified if the experience was healthy, had scriptural relevance, was intense and inspiring, if they felt convinced it actually occurred, and the spontaneity of the experience (DeHoff, 2015). Source norms were also used; this construct is defined as using manuals or textbooks to help place the experience into a category, if it fits. If the experience does not fit into a category, that is further information to help categorize the experience as psychotic (DeHoff, 2015). Personal experience was reported by 75% of the clergy

members, endorsing that they helped determine the category of the experience based upon previous personal experiences that they have encountered (DeHoff, 2015). Seventy percent of the clergy members stated that they use religious training, and 50% reported using the Bible and the scriptures to determine if the experience can be within the context and content of what may have already occurred. Finally, intuition and "gut feeling"—feeling like something "just was not right" or was possibly false—helped members of this clergy delineate the differences (DeHoff, 2015).

Spiritual, psychotic, or both? In the DeHoff (2015) study, spiritual experiences included supernatural healing, spontaneous occurrences without any other explanation, or feeling God's presence throughout the day. When God heals someone supernaturally, it has been described as a spiritual encounter in which a person may feel an electric current piercing the body or a physical sensation of warmth. DeHoff also described unhealthy and demonic spiritual experiences, such as seeing a demon or spirit and demonic possession. Psychotic experiences were defined as hearing voices that endorsed harm to oneself or others, or being within a religious experience that includes an element of dissonance that is inconsistent with the tenets of Christianity (DeHoff, 2015). In an effort to tease out an experience that may have elements of both, 45% of clergy members endorsed the belief that individuals may have an experience that can be impacted by both spiritual and psychotic features (DeHoff, 2015). If the clergy members already knew that the person who had the experience had a prior mental health history or if the experience seems genuine but the content or context appears bizarre, it was denoted a psychotic experience (DeHoff, 2015). This study highlighted the difficulties clergy members may

encounter as they try to decipher a religious experience from a psychotic experience, especially without any formalized training in mental health.

Ultimately, the barriers that exist in regard to help-seeking behaviors within the African American community interfere with the effectiveness and efficiency of services that can be provided. Historical and cultural factors have left an imprint within this community of color that has led to a foundation of abuse, violence, and disparities. In order to work collaboratively and competently with African Americans, clinicians must consider, acknowledge, and be open to discussing the sociopolitical impacts of institutionalized racism within America. In addition to the historical factors, present-day factors can further undermine any efforts made to reach this population. Even if clinicians learn to operate from a culturally sensitive perspective, the fact remains that services are sub-par, inaccessible, and unavailable. Not only can the system of mental health be revamped to focus on improving clinicians' cultural competencies, but it would be a disservice if it failed to simultaneously address the systemic issues of poverty and institutionalized racism that further impede access to services.

The "Black Church"

The concepts of religiosity and spirituality are often used interchangeably and have caused a great debate in religion research. Some theorists attempt to use the terms religion and spirituality interchangeably, but others believe fully that these two constructs are entirely different. Religion can be viewed as a shared system of beliefs and rituals that are associated with a God or gods (Mattis & Jagers, 2001). Religiosity is the practice of religion, and how one adheres to one's religious beliefs, doctrines, and applications (Mattis & Jagers, 2001; Mattis, 2002). Whereas religion typically implies an organized

institution with a group leader, spirituality can be less structured. Spirituality has been described as recognition of a "force" that transcends everything human and non-human; it is the belief in the sacred and transcendent properties of nature that provide both meaning and purpose to one's life that is evidenced by the interconnectedness of human and non-human entities (Mattis, 2002; Rambo & Farris, 2012). Spirituality has also been described as a belief in a higher power or being. Both religion and spirituality have been at the core of the African American community and cultural experiences (Mattis & Jagers, 2001). This firm belief in religiosity and spirituality within the African American community led to the existence of the cultural phenomenon known as the "Black Church."

Approximately 80% of African Americans identify religion as a vital component in their lives, with 59% reporting affiliation with the Black Church (Avent et al., 2015). According to Douglas and Hopson (2001), the Black Church is defined as "a Protestant multitudinous community of churches, which are diversified by origin, denomination, doctrine, worshipping culture, spiritual expression, class, size, and other less obvious factors" (p. 96). When accurately describing the Black Church, it is not only the literal church building, but an overall religious experience and community. Black churches were formed due to the needs of the African American community of that time, but each Black church was formed to address the specific issues within the members of their community and congregation. Black churches that were formed in the South were not necessarily based on the same tenets and principles of those formed in the North. The underlying purpose was to provide African Americans a safe haven to allow them the ability to express themselves freely in a religious context.

Role of the Black Church. During the 19th century, the Black Church assisted with the needs of the church members of that time. Church buildings were used not only as places of worship but as community centers, schools, political halls, and shelters for the homeless. Black churches have been instrumental in supporting Black communities in social protection and welfare and in economic and education goals (Chatters, Taylor, Bullard, & Jackson, 2009). Not only did they provide their members with tangible benefits, but they also provided a sense of history, tradition, guidance, hope, social justice, and community (Thompson & McRae, 2001). The desire to belong in a community is fundamental to all humans and is a primary social motivation that exists (Thompson & McRae, 2001). The Black Church fulfills this desire to belong, which improves the affective and emotional states of its members (Thompson & McRae, 2001).

The Black Church is one of the few Black institutions that have maintained cultural roots post-slavery, thus serving as a central hub that preserves Black culture (Douglas & Hopson, 2001). Further, the Church provides African Americans with a safe haven and a shelter away from the hostile and, at times, oppressive atmosphere of the dominant culture (Adksion-Bradley et al., 2005; Plunkett, 2013). It also allows African Americans to gain status and privileges that are not afforded to them within the majority culture and mainstream society (Douglas & Hopson, 2001). Lastly, as the Black Church continues to provide social, financial, psychological, religious, and political gains for its members, it also functions as a support group and source of affirmation to address the psychological needs of congregants (Plunkett, 2013).

Historically, the Black Church represented seven different denominations: “African Methodist Episcopal Church, African Methodist Episcopal Zion Church, Christian

Methodist Episcopal Church, National Baptist Convention, National Baptist Convention of America, Progressive National Baptist Convent, and Church of God in Christ" (Plunkett, 2013, p. 2010). Pentecostalism was not one of the original seven denominations formed within the African American community, but it has been recognized as its own denomination for a century. The present study focused on Pentecostalism as a prominent African American Christian denomination. Pentecostalism was chosen as the focus for this study as a result of the tenets inherent in Pentecostalism that may directly influence perceptions of mental health and mental illness.

Prominent denominations. Overall, African Americans are more likely to identify as Christian than their White counterparts, and are more likely than any other race to identify as Protestant (Masci, Mohamed, & Smith, 2018). Approximately 80% of African Americans identify as Christian in comparison to the general population's 70% (Masci et al., 2018). Five percent of the African American population identifies as Catholic in comparison to the 21% of the overall American population, and roughly 2% of the African American population identifies as Muslim in comparison to the 1% of the United States (Masci et al., 2018). Interestingly, African American men are more likely than African American women to identify as Muslim, at 4% and 1%, respectively. Additionally, 18% of the African American population identify as unaffiliated, whereas 23% of the United States population identifies as unaffiliated (Masci et al., 2018). When compared to the general population, African Americans are less likely to identify as unaffiliated, which includes atheist, agnostic, or non-religious. Despite this, there has been a 6% increase in the number of African Americans that identify as unaffiliated

(Masci et al., 2018). Research suggests that this increase may be a result of generational differences, with Millennials aged 18 to 29 rated as the highest African American group to identify as unaffiliated and adults aged 65 and older ranked as the least likely to identify as unaffiliated. Similarly, this increase in unaffiliated status parallels a similar trend observed in the general American population (Masci et al., 2018). The following contrasts two prominent African American Christian denominations: the African Methodist Episcopal (AME) Church and the Baptist Church, in an attempt to further assert why Pentecostalism was chosen for this study.

The AME Church consists of approximately 4 million members, and represents mainly people of African descent. Fundamentally, the AME Church adheres to the doctrine of Methodism; a split occurred as a result of racism that was experienced by African American Methodists during the early 1800's (The Official Website: African American Methodist Episcopal Church, 2018). Richard Allen opposed the oppression and mistreatment that he witnessed; therefore, he chose to disconnect from the Methodist Church. Although its doctrinal roots stem from Methodism, which informs their rules and regulations, the organizational structure adheres to an Episcopalian framework (The Official Website: African American Methodist Episcopal Church, 2018). Methodists believe in God the Father, God the Son, and God the Holy Spirit, and also emphasize the divinity of Jesus. Methodists believe that salvation is a work of God and cannot be earned by works (Bowman, 2003). Baptism and Holy Communion are two sacraments that are recognized by Methodists. Most Methodist churches practice infant baptism, but confirmation, or water baptism after you become saved, is a promise that is made in front

of God (Bowman, 2003; The Official Website: African American Methodist Episcopal Church, 2018).

In contrast, the Baptist Church is credited with approximately 25 to 30 million members in the United States, and 100 million members worldwide (Bowman, 2003). The Black Baptist Church was formed around the Antebellum era, when both freed Blacks and slaves were expected to belong to White Baptist Associations. Black congregations by law were required to have White ministers and fall under their supervision. Therefore, Black Baptists formed their own churches of worship, serving as leaders and operating and governing by their own doctrine, regulations, and organization. Within the Baptist Church, the belief is that the body of Christ is the Church. The Church is formed of congregations within the community. Under the Baptist tradition, members must be baptized believers of Christ, and the officers within the Church are pastors and deacons (Bowman, 2003). The Baptist Church believes that Baptism is only done through immersion in water for believers of Christ (Bowman, 2003). Baptist churches place great emphasis on evangelism and missions. Present-day Baptists include primarily Southern Baptists, American Baptists, and National Baptists (Bowman, 2003).

How the scriptures are viewed, the identities of God and Jesus, the process of being born again, and beliefs about the afterlife are components that are similar within many African American Christian denominations. Pentecostals, Baptists, and Methodists all believe that the Bible is infallible and inspired by God (Bowman, 2003). God is the creator of all things and is viewed as a part of the Trinity, including God the Father, God the Son, and God the Holy Spirit. God the Son is Jesus, and each denomination believes that he is fully God and fully human, was born of a virgin, and died on the cross for our

sins (Bowman, 2003). Individuals are believed to be saved by God's grace; they believe Jesus is God, and that the souls of the believers will go to Heaven upon death (Bowman, 2003). Each of these three denominations formed as a splinter, or through a resistance against the teachings of White preachers and pastors of that time, who viewed African Americans as inferior, refused to allow them to hold leadership positions, and subjugated them within these religious contexts. The most pronounced difference between Pentecostalism, the AME Church, and the Baptist Church is the belief in the "gifts of the spirit." Although many African American denominations are now beginning to operate in and believe in the works of the Holy Spirit, this belief is fundamental to and began with the Pentecostal Christian experience. This is the primary reason why Pentecostalism was chosen as the African American denomination of this study.

Pentecostalism

Development and current statistics. Pentecostal Christians make up the fastest growing Christian denomination in the world (Parker, 2014). Currently, Pentecostal Christians comprise 27% of all Christians and approximately 8.5% of the world's overall population (Dobbins, 2014). A quarter of the world's 2 billion Christians identify as Pentecostal (Shepard Payne, 2008). There is debate about who should be credited as the "father of Pentecostalism" or the individual who developed the doctrine and practice of this denomination (Irvin, 2005). The first individual who has received credit for founding Pentecostalism is Charles Parham, who was a European American evangelist who created the doctrine of Pentecostalism and associated it with speaking in tongues. He referenced Acts Chapter 2, a passage in the Bible, as evidence supporting speaking in tongues, which is proof that someone has received the Baptism of the Holy Spirit (Irvin,

2005). Parham spearheaded a Bible school that was located in Topeka, Kansas in 1901. William Seymour has also been credited as the "father of Pentecostalism." He was an African American "holiness" preacher who moved to Los Angeles, California from Texas in 1906 and was the leader of the Azusa Street Revival that began in 1906. Seymour was a student under Parham and attended one of his classes that was located in Texas; however, because of his race, he was forced to sit outside of the classroom (Irvin, 2005). As a result of this experience, his revival is credited for including individuals who are marginalized within their communities because of their racial backgrounds. Additionally, his revival allowed individuals to be equal within his church (Anderson, 2005).

Seymour's belief of speaking in tongues led him to being excommunicated from the church that he pastored in Los Angeles, and led to his development of the Azusa Street Revival (Irvin, 2005). The revival lasted for approximately three years, and included daily 12-hour meetings (Anderson, 2005; Irvin, 2005). Pentecostalism spread to over 25 nations within a matter of two years (Anderson, 2005). Although Seymour advocated for everyone to be a part of his ministry regardless of their social identities, by 1915, his church was predominately Black and mostly all of his White members had left (Irvin, 2005).

Pentecostal Christian revival spread throughout the United States and Africa. Pentecostalism in Africa has a significant history originating from various native movements, including African Prophetism, African Indigenous Churches, and African traditional religions (Duncombe, 2012). The African philosophies that were followed were in direct opposition to the Western views of Christianity. Typically, the West has approached Christianity from a theoretical standpoint, whereas the African viewpoint

emphasizes a more holistic approach, considering spirituality as fused with all of life, including the natural world (Duncombe, 2012). The structure and beliefs inherent in Pentecostalism appeared to be a logical addition within the African religious culture. The belief in spiritual beings or spirits within Pentecostalism fits into the African worldview of spiritual holism (Duncombe, 2012). Pentecostalism offered a way to fulfill Africans' needs for healing, protection from evil spirits, and restoration for the weak. Historically, Pentecostalism placed less emphasis on requiring formal education in order to receive spiritual authority, and instead emphasized an overall religious experience, including both receiving the calling and the gifting of the Holy Spirit (Duncombe, 2012). This was consistent with Africans' cultural beliefs that also de-emphasized formal Western education.

Similar to African American Pentecostals, African preachers emphasized the manifestation of God's divine power through prophecy, healing, and other phenomena. One of the most famous African Pentecostal prophets and evangelists was William Wade Harris. Harris was a Liberian prophet who spread Pentecostal tenets across the Ivory Coast to Ghana in 1914. His missionary ministry led to thousands of Africans converting to Christianity. He dressed in a robe, carried a Bible and a bowl for Baptism, and operated in the gifts of the Spirit to minster to lost souls using miracles and miraculous healing (Anderson, 2000; Duncombe, 2012). During the 1970s, the Charismatic Renewal of Pentecostalism spread the message of prosperity, which was well received by poorer African communities. Preachers taught that receiving the Holy Spirit and accepting Jesus as Lord and Savior would meet their needs. This prosperity message vowed both health and wealth to those who ascribed to these beliefs, which aligned with the needs of many

Africans (Anderson, 2000; Duncombe, 2012). Consequently, Pentecostalism met the physical, emotional, and spiritual needs of both African Americans and Africans, offering a resolution for life stressors and a way to cope with a hostile and rejecting world.

Pentecostal beliefs, standards, and practices. In Pentecostalism, professing Christianity and possessing a Christian identity goes along with the assumption that the individual has a continual, uninterrupted, personal relationship with God the Savior (Koenig, 1998). The term "Savior" is used to reference Jesus the Christ, who saves souls from Hell, granting salvation to all who seek him (Koenig, 1998). In order to be granted salvation, an individual must be "born again," which means believing that Jesus is God and accepting him into his or her life (Koenig, 1998).

There are eight components associated with Pentecostal worship services: worship, devotional songs, prayer, tithes and offerings, reading of the scriptures, sermon, alter call, and benediction (Shepard Payne, 2008). Worship in a Pentecostal church tends to be lively and very expressive, which may include operating in the "gifts of the Holy Spirit," which is a ritual that is associated strongly with Pentecostalism (Parker, 2014). The Holy Spirit (Holy Ghost) is the third person within the trinity, alongside God the Father and God the Son (Jesus). The Holy Spirit is God's active force, who He sends out to "touch" His people so that they can feel His presence. Feeling His presence can be described as a feeling of warmth or safety, which can be evidenced by the presence of tears.

The "gifts of the Holy Spirit" include laying on of hands (when an individual will place anointing oil on someone's head, and will touch him or her on his or her body, usually the head) to heal the sick and to deliver from demonic possession, testimonials of

what God has done, "shouting" (catching the Spirit by rejoicing in a loud voice and dancing), and speaking in tongues (heavenly language that is interpreted for the benefit of the congregation; Parker, 2014). A religious understanding of healing means "wholeness or the restoration of a broken body, mind, or spirit" (Koenig, 1998, p. 57). The etiology of that brokenness is often attributed to sin, and an interruption in the congregant's relationship with God (Koenig, 1998). Speaking in tongues is deemed a "heavenly language" in which the individuals who have been baptized of the Holy Spirit are able to operate. Operating in the gifts of the Spirit is evidence of being baptized by the Holy Spirit, and that God is omnipresent, always present and available to heal and deliver (Parker, 2014). Pentecostal clergy preach "the gospel," which includes messages about forgiveness from sin, healing the sick through prayer, being baptized by the Holy Spirit, and Jesus' second coming into the world (Dobbins, 2014).

Pentecostal views of mental illness and healing. The general attribution theory describes the ways in which individuals begin to accept their own illnesses. The primary assumption is that individuals want to explain and understand their experiences because they believe it may increase their chances of predicting and controlling these events in the future (Hartog & Gow, 2005). How liberal one's religious beliefs are determines the type of attributions applied. Typically, those who are fundamentalist may view mental health afflictions as a result of sin or a moral weakness, whereas those with more liberal views may accept that there may be alternative and secular explanations of mental illness (Hartog & Gow, 2005).

To many African American Pentecostal clergy members, the etiology of mental illness is spiritual (Dempsey, Butler, & Gaither, 2016). Those with mental illnesses have

been perceived as being possessed by demonic forces and living sinful lifestyles and, as a result, receiving divine punishment, or as lacking faith and prayer in their spiritual lives (Amerongen & Cook, 2010; Wesselmann & Graziano, 2010). As Pentecostal believers, clergy may emphasize how supernatural forces influence the etiology and treatment of mental disorders (Mercer, 2013). As mentioned earlier, there are three main beliefs about mental illness as it relates to religion: demonic possession, divine punishment, and a lack of faith or prayer (Amerongen & Cook, 2010; Wesselmann & Graziano, 2010).

Demonic possession. Religious persons use demonic possession as one explanation to conceptualize mental illness. Both emotional and psychological problems are viewed as being influenced by the devil and/or demons (Wesselmann & Graziano, 2010). In the Pentecostal view in particular, mental illness is viewed as caused by the presence of demons indwelling someone's body (Mercer, 2013). The only way to expel the demons is through deliverance, of which the primary form is exorcism. Exorcism is the act of praying until the demon has been released from the person's body and he or she is free of demonic possession (Mercer, 2013). Not only is there a strong belief in demonic possession causing mental illness, but of sin being a direct cause as well. This supports the view that mental illness is a form of divine punishment (Gray, 2001).

Sin and divine punishment. Pentecostal clergy members may view those who suffer from mental illness as engaging in sinful lifestyles or being morally weak and, thus, stricken with mental illness as a divine punishment from God (Dobbins, 2014; Wesselmann & Graziano, 2010). Consequently, mental illness is often viewed as a judgment for sins and wrongdoings committed by the person, and as God's attempt at teaching the forsaken person a spiritual lesson (Wesselmann & Graziano, 2010). This

would lead someone to confess his or her sins and ask for forgiveness in order to receive healing, instead of seeking out mental health services. A spiritual leader would instead be sought to guide the patient-parishioner through the process of renunciation of his or her sins. Since the fundamental belief originates from an understanding of sin, one would not, therefore, seek secular providers to treat sin. This may also decrease one's belief in mental illness entirely; if mental or physical health problems are attributed to religious beliefs, then the existence of mental illness may be challenged.

Lack of faith or religious flaws. Other Pentecostals may believe that they have not received total healing as a result of lacking faith in God and His ability to deliver, or through praying ineffectively (Dobbins, 2014; Wesselmann & Graziano, 2010). In this case, the religious person is directly responsible for the reason he or she is suffering from a mental illness, similar to those who have blatantly sinned against God. Those who believe that mental illness can be attributed to a moral flaw or a spiritual weakness may be less likely to seek treatment from secular providers (Wesselmann & Graziano, 2010). This would limit and deter someone because mental health providers would presumably not be educated on ways to increase one's faith in God. Therefore, spiritual leaders would be sought after instead, in order to assist in strengthening one's faith in God.

Healing of mental illness. There are two schools of thought regarding healing within Pentecostalism. The first focuses on the idea that curing or "healing" mental health and physical health issues is done directly from intervention by God (Plunkkett, 2013). The second views healing slightly differently, positing that God will work through someone to heal an individual (Plunkkett, 2013). With either school of thought, God is credited for the physical and mental healing of the congregant.

Pentecostal congregants rely on scripture and prayer as a part of their faith in receiving God's healing, thereby decreasing the likelihood that they would rely on or trust secular resources to provide healing. Crediting God alone for one's healing may decrease the likelihood that one would seek sources outside of one's faith, instead likely relying solely on God for healing. Therefore, Pentecostals may view secular interventions as against the will of God, lacking in faith, or as a form of rebellion. A study conducted by Shepard Payne (2008) suggested that reliance on Jesus was the way to be healed. Sermons can be communication outlets that also carry the message that seeking mental health services would be ineffective, thereby perpetuating stigma. Such messages, if given to congregants on a weekly basis, may affect utilization of treatment services by individuals who are plagued by mental illness or related issues (Shepard Payne, 2008).

Clergy's Role in Mental Health Treatment

The Black Church plays an integral role in "healing" its congregants. Pentecostal pastors, like mental health professionals, focus on transforming the minds of their congregants (Taylor et al., 2000). Patient-parishioners who have religious affiliations often report the desire to have spiritual beliefs incorporated and integrated into their mental health treatment (Kramer et al., 2007). Patient-parishioners who have faith integrated into their treatment with mental health providers have better treatment outcomes (Kramer et al., 2007). There are various reasons why clergy members do not refer parishioners to formal mental health treatment, including but not limited to the lack of follow-up once the referral has been made, inability to assess the standard of resources available, financial barriers, fear of misdiagnosis and over-medication, and the lack of

noticeable common values between the clergy member and mental health professionals (Koenig,1998). Research indicates that younger ministers and those with college degrees are more open to referring their congregants when compared to older ministers and those without college degrees (Allen et al., 2010). Because of the obstacles mentioned, there are many reasons why seeking help from clergy is advantageous over mental health professionals.

One advantage that clergy members provide is that their service is free; those from lower socioeconomic backgrounds may not be able to afford services from mental health professionals because of the economic burden associated with those services. Clergy members are often more available and accessible. Referrals are often needed to seek mental health services, whereas clergy members may be approached directly and referrals are not always necessary. Clergy members are able to make personal home visits to their parishioners, and this is a boundary that clinicians often avoid. Clergy members may have an easier time connecting and building relationships with their congregants as a result of their already existing relationships founded on faith and trust. Where it may take a mental health provider a longer time to build trust, clergy members presumably have existing relationships with their parishioners and are, therefore, able to foster connections much easier and sooner.

It has been found that roughly 24% of parishioners who seek mental health treatment only seek help from members of their clergy; and a surprising 40% seek help from both clergy and mental health professionals (Kramer et al., 2007). Congregants often seek guidance from their ministers for religious concerns, relationship and grief counseling, family problems, health concerns, and financial/work problems (Allen et al.,

2010). Problems that are often not addressed by clergy members include marital problems, sexual problems, domestic violence, and substance use (Allen et al., 2010). As a result, if someone is presenting with any of these conflicts, he or she is less likely to seek help at all. This reaffirms how challenging it may be to seek and receive clinical services, and why a trusted spiritual advisor is a more likely sought source for guidance and healing.

The Church has maintained an integral role in the economic, psychological, and social lives of African Americans (Aten, Topping, Denney, & Bayne, 2010). As leaders in the Church, clergy members are integral to the provision of social, spiritual, and psychological support to their congregants. There are several factors specific to ministers that highlight their multiple roles in the lives of their congregants. First, the pastor is the most prominent figure in the Church (Aten et al., 2010). Second, ministers may manage multiple roles in the Church, including assisting the pastor, providing additional support to the members, or assisting in provision of education about health-related changes of the congregants (Aten et al., 2010). Third, ministers and pastors at times may be the only professionals that some individuals encounter (Aten et al., 2010; Chalfant et al., 1990). Many people rely on pastors and ministers to provide guidance and information, and if the ministers and pastors do not support other professional services, this may limit parishioners from seeking additional help.

Finally, and germane to this study, ministers and pastors can function as gatekeepers to non-religious services, referring their members to formal mental health services as deemed appropriate (Aten et al., 2010). The term “gatekeeper” is used to refer to clergy members as frontline providers who are the first assessors of the needs of

individuals presenting in crisis (Allen et al., 2010). Ideally, the clergy member would assess the congregant and would then refer to more appropriate and formal mental health services; however, research suggests that not only do clergy members seldom refer to other treatment providers, but that individuals who receive help from their clergy are less likely to seek additional mental health care (Allen et al., 2010).

Despite other denominations also believing in and operating in the "gifts of the Spirit," this is the hallmark tenet and is a fundamental practice associated with Pentecostalism. Many other denominations have adopted this belief and have incorporated it into services and evangelism, but Pentecostalism is the first denomination credited for operating in these gifts. Despite the many similarities between the predominately Black denominations described previously, African American Pentecostal Christians were sampled for this study because of the transcending, inherent, and fundamental belief in the "gifts of the Spirit" as well as the faith healing that is associated with the denomination. These beliefs are ingrained and intrinsic within this population and may affect and influence one's perception of mental health and treatment and, consequently, dictate referral practices. Messages provided to congregants may unintentionally delay treatment-seeking efforts for those who are suffering from a mental illness. A reasonable and impactful approach that mental health professionals can use in the facilitation of the psychological health of African Americans is to collaborate with African American clergy. Since church leaders are highly respected and function as the gatekeepers for their congregations, a better understanding of their views about secular mental health services could help African Americans seek and receive more equitable and culturally sensitive mental health treatment.

Purpose of the Study

Church leaders are viewed as the gatekeepers for their congregations. Thus, a better understanding of their views and perceptions about mental health services may assist mental health professionals in advertising and providing more culturally sensitive treatment to this population. The purpose of this study was to evaluate Pentecostal African American clergy members' perceptions of mental health treatment and their subsequent referral practices. There may be a way to bridge the gap in the delay of treatment for African Americans if there can be more unity between the Church and the field of psychology.

Research Questions

Addressing the following research questions aimed to highlight the perspectives and beliefs of the prominent African American Christian denomination, with the additional aim of understanding how religion and religious views influence referral practices and overall beliefs about mental health and illness.

1. How do Pentecostal African American clergy members view mental health and mental illness?
2. How do their views about these concepts inform their referral practices to outside agencies other than the Church? What influences their decision to refer or not to refer?
3. How do they perceive mental health delivery for those within their community?
4. How do Pentecostal clergy members respond to parishioners who seek their counsel on mental health issues?
5. What are Pentecostal African American clergy members advising their parishioners about mental health services based upon their perceptions of these services?

Chapter 3: Method

Study Design

This study was a qualitative grounded theory design. This design was chosen due to the scarcity of research explaining how African American clergy members view mental health. Grounded theory allows a discovery process to unfold in order to gain new or additional knowledge in an area that has been researched minimally. The qualitative research design is known as "hypothesis-generating research" because the ultimate goal is to derive hypotheses that can be further deduced to a theory that can explain the phenomenon investigated (Auerbach & Silverstein, 2003). This form of research emphasizes two principles that distinguish it from quantitative research, including the use of questions instead of variables and the generation of hypotheses via theoretical sampling and coding (Auerbach & Silverstein, 2003). Grounded theory proposes that only through interactions and experiences of the participants can one gain further knowledge and meaning. Through this view, participants are seen as the "experts" on the phenomenon being studied and their subjective experiences are explored as a way to further generate hypotheses and theories that explain the phenomenon at hand. This study included the implementation of semi-structured interviews, the Spiritual Experience Index-Revised (SEI-R), and a demographic questionnaire with African American Pentecostal clergy members.

Participants

The study sample included 13 participants that came from a total of five churches and consisted of six males and seven females between the ages of 28 and 69, with a mean age of 57. One participant was turned away from the study because he did not meet

inclusion criteria. Participants were recruited from local Pentecostal churches. A snowball sampling method was employed to receive additional participants from other local Pentecostal churches. Recruitment began in March 2017 and ended in November 2017.

Table 1 shows participant demographic information, including gender, age, degree obtained, years as a Christian, years as a clergy member, offices held, whether he or she has referred members for mental health counseling, and whether he or she has been exposed to mental illness. Degrees obtained by clergy members ranged from high school diploma to doctoral degree. The average number of years as a Christian ranged from 16 to 69 years, with a mean of 38 years. Roles that clergy members held included pastor, elder, bishop, prophetess, deacon, youth leader, Sunday school teacher, evangelist, music director, board member, missionary, co-Pastor, and women's ministry leader. The average number of years as a clergy member ranged from 7 to 33 years, with a mean of 20 years.

The researcher experienced a delay in recruitment and difficulties acquiring a sample. Clergy members were not all responsive, nor were they receptive to being part of a research study. In qualitative study designs, it is difficult to predict what sample size will be truly representative of the population being studied and what size sample will truly saturate the theory being explored, but researchers have suggested approximately 20 participants is adequate (Creswell, 1998; Mason, 2010). This researcher acquired 13 participants, and it was presumed that this may be because of the stigma that exists with engaging in secular research, apprehension discussing intimate details about religious beliefs, and distrust of mental health providers and the field of psychology.

Inclusion criteria. The participants were pre-screened according to the following eligibility criteria: each potential participant had to be a clergy member of a predominately African American Pentecostal denominational church, at least 18 years of age, identified as African American, and fluent in English.

Exclusion criteria. Participants were excluded from the study for the following reasons: having any intellectual disabilities, clergy members who held dual roles as mental health professionals, or clergy members from any other religious denomination. The study was limited to Pentecostal clergy in an attempt to control for potential variance due to denominational differences.

Recruitment. In order to conduct this study, permission was first obtained from the institutional review board (IRB) of the researcher's institution. The researcher contacted the pastors of local Pentecostal churches in person, by telephone, and via e-mail to discuss the purpose of the study and to extend contact to their clergy members. The researcher provided the e-mail advertisement and informed consent form for the pastors to provide to interested clergy members (Appendix A). The pastors of the churches forwarded the information to their clergy members and to other clergy members in their network who could possibly qualify to participate. One church allowed the researcher to make an announcement during morning service and another church allowed the researcher to make an announcement before Bible study. The participant who did not meet eligibility criteria was thanked for his time and asked to mention the study to other African American Pentecostal clergy members who may be interested in participating in the study.

Table 1

Participant Demographics

Participant	Gender	Age	Degree	Years as Christian	Years Clergy	Offices Held	Referred Members	Exposed to Mental Illness
1A	Male	58	Associates	46	9	Sunday school teacher, choir member, deacon	No	Yes
2B	Female	57	Masters	30	15	Music Director, Youth Leader, Sunday School Teacher	No	Yes
3C	Male	69	Diploma	38	30	Deacon, Evangelist, Elder, Bishop, Pastor	Yes	Yes
4D	Female	52	Doctoral	40	21	Elder and Prophetess	Yes	Yes
5E	Male	59	Associates	27	19	Evangelist and Deacon	No	Yes
6F	Male	28	Bachelors	16	7	Youth Leader	No	Yes
7G	Female	67	Diploma	45	10	Usher, Missionary	No	Yes
8H	Female	45	Masters	24	23	Sunday School Teacher Brother's Keeper, Bible Institute Assistant	Yes	Yes
9I	Female	53	Associates	42	18	Co-Pastor, Administrator	No	Yes
10J	Female	60	Masters	53	Does not know	Teacher, Choir Director, Youth Leader, Women's Ministry Leader	Yes	Yes
11K	Male	60	Associates	39	33	Teacher, Deacon, Elder, Minister, Bishop	Yes	Yes
12L	Female	69	Diploma	30	25	Pastor	No	Yes
13M	Male	69	Bachelors	69	27	Pastor	Yes	Yes

Procedure

Once a potential participant contacted the researcher, the purpose of the study, potential risks and benefits of participating, and characteristics of the interview process were all explained. The researcher then screened the participant to determine eligibility and to ensure that he or she met the criteria to participate in this study. A qualifying participant had at least one week to review the informed consent document. A time and date were arranged to meet in person to complete the measures and conduct the interview.

At the arranged date, the researcher began by reviewing the informed consent document with the participant, and after answering any remaining questions about the study, had the participant sign the form. Each participant was first given the demographic questionnaire followed by the SEI-R, and then the semi-structured interview began. A non-identifiable code was assigned to each participant and used for collecting measurement data to identify him or her throughout the coding process. At the end of each interview, the participant was provided with information regarding mental health services and treatment. The researcher transcribed the interviews, removing identifying information used during the interview, and replacing them with the non-identifiable codes assigned to participants.

An e-mail was distributed in order to recruit a validation team. A validation team was used to help analyze data in an attempt to enhance the validity and reliability of the study. The researcher and the validation team—consisting of two doctoral-level PCOM graduate students—met on three occasions. On the first occasion, prior to beginning the coding process, the researcher met with the team to provide training in reference to

coding strategies for the study. During that meeting, after the training was completed, each coder was provided with the same set of four transcribed, diverse interviews to begin the open coding process. The original transcripts included three males and one female, each differing in levels of education, age, role in the church, and category based on the SEI-R, which led to the diversity in transcripts chosen.

Each team member was encouraged to engage in the coding process independently, to highlight relevant words and generate new ideas, in an attempt to produce the most accurate and salient results from the data. During the second meeting, the validation team reviewed the codes that were derived from the same four transcripts to ensure inter-rater reliability. At that point, the determined codes were then used to interpret the remaining nine transcripts. At the final meeting, the validation team agreed upon the final categories, which allowed the researcher to organize sub-categories, generate themes, and reach conceptual density.

Study Instruments

Semi-structured interview. The semi-structured interview was developed by the researcher, and was designed to use open-ended questions to determine each clergy member's perceptions of mental health. The interview questions focused on the clergy members' specific experiences with mental illness. They were asked whether they have encountered individuals with mental illness and, if so, to describe those experiences. Additionally, they were asked about their experiences with treating mental illness in their church, and how they have been affected and influenced by their religious beliefs. Additional questions were added during the process of interviews as necessary. The questions were geared toward understanding their perceptions of mental health and

mental illness, their level of comfort managing parishioners who present with mental disorders, and the aftermath of the counseling provided, which included whether they chose to refer parishioners for more secular mental health treatment. For a full list of questions, see Appendix D.

Demographic questionnaire. The demographic questionnaire was developed by the researcher, and was designed to gather basic background information of the participants involved in the study, to assist in the recruitment process, and to gather information that may be pertinent for the inclusion and exclusion criteria. The demographic questionnaire requested information about personal encounters with mental illness, role as a clergy member, educational level, secular and Christian degrees and certifications obtained, age, gender, and years in ministry. For an example of the questionnaire, please see Appendix B.

Spiritual Experience Index-Revised. The SEI-R was designed to assess the level of self-identified spirituality and spiritual maturity (Genia, 1997). It was intended to apply to individuals from varied religious backgrounds (Genia, 1997). The works of Gordon Allport, William James, and Erich Fromm influenced the theoretical foundation of this assessment (Genia, 1997). The criteria used for the foundation of this assessment included the following:

> Transcendent relationship to something greater than oneself; consistency of lifestyle, including moral behavior, with spiritual values; commitment without absolute certainty; appreciation of spiritual diversity; absence of egocentricity and magical thinking; equal emphasis on both reason and emotion; mature concern for others; tolerance and human growth strongly encouraged; struggles to understand

> evil and suffering; a felt sense of meaning and purpose; and ample room for both traditional beliefs and private interpretations. (Genia, 1997, p. 345)

There were originally 38 items; however, in the revised edition, only 23 items remained (Genia, 1997). The items were divided into two sections. The first 13 items refer to faith as a source of support and they comprise the Spiritual Support (SS) subscale (Genia, 1997). The other 10 items refer to the level of spiritual openness one endorses, and are defined subsequently as the Spiritual Openness (SO) subscale (Genia, 1997). Items are rated on a Likert scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). Genia (1997) used a split mean procedure to analyze the results obtained in her exploratory study. The split mean procedure was used in order to place participants into four spiritual types: growth-oriented types, underdeveloped types, dogmatic types, and transitional types. A split mean procedure changes a continuous variable into two categories; high scorers include those above the mean, and low scorers include those below the mean. A primary problem with using this procedure to analyze data is that the distribution of scores vary by sample, and the means used to split scores varies by sample. Therefore, a specific range of scores does not exist, as it depends upon the present sample. Normative data across both populations and cultures for the SEI-R are unavailable currently, which would have allowed the opportunity to compare this study's sample means to normative sample means. Consequently, with this procedure, it may be difficult to draw conclusions based on the scores obtained from the participants.

There were mean scores obtained for both the SS and SO subscales. The mean score for the SS subscale was 54, and the mean score obtained for the SO subscale was 44. The alpha coefficient of the SS subscale is .95, and of the SO subscale is .86 (Genia,

1997). This scale is both reliable and valid for construct and discriminate validity in measuring spiritual openness and maturity (Genia, 1997). This measure was used in this study for descriptive purposes in an effort to categorize participants who endorse more dogmatic or open views. Studies have shown that clergy members' levels of education, conservative or liberal views, and religious beliefs about mental illness all influence whether they refer parishioners to secular mental health services.

Data Analysis

The specific methodology chosen for this study was grounded theory. Grounded theory research does not necessarily begin with a specific theory in mind; often, a theory is generated during data collection. Analysis in grounded theory is open and free (Corbin & Strauss, 2008). One uses the process of analysis in order to generate or develop concepts that are derived from data (Corbin & Strauss, 2008). Additionally, new theories can be developed and concepts can be derived from the data; this is known as theoretical sampling (Corbin & Strauss, 2008). The use of grounded theory allows the researcher to derive theories from the data that are collected from the observations, interviews, and processes of those involved in the study.

The true value of grounded theory is based upon how relevant the developed theory relates to other individuals similar to those studied (Corbin & Strauss, 2008). Coding is an open, free, and step-by-step process that explores certain concepts within the data, generating themes that are essential to the research question and that clearly describe and relate to not only the phenomenon studied but the process and experiences of the participants as well (Corbin & Strauss, 2008). Open, axial, and selective coding were employed in this study. Open coding consists of microanalysis of data that allows

for the categories and subcategories within data to be compared and contrasted to assist in the generation of themes (Corbin & Strauss, 2008). Insight is derived during open coding by identifying similarities and differences between the developing categories, by comparing and contrasting certain words and phrases that emerge as relevant to the data (Corbin & Strauss, 2008).

Axial coding uses the six Cs, which further describe the data gleaned. The six Cs include cause, consequence, covariance, contingencies, context, and conditions (Corbin & Strauss, 2008). During axial coding, the development of categories is further explored by examining the relationships between them (Corbin & Strauss, 2008). Finally, selective coding refers to the grouping of axial codes to form the hypotheses that will generate new theories (Corbin & Strauss, 2008). Selective coding focuses on the integration of categories and subcategories into distinct themes for the foundation of theory development. Bracketing was used in an effort to allow the validation team to self-reflect on their prior knowledge and biases as they relate to the topic at hand, with a goal of acknowledging them to remain open-minded throughout the analysis process. Within each theme emerged subthemes, which were commonalities that existed within each major theme.

Analyst triangulation was achieved by using a validation team to increase the validity of the data analysis. Analyst triangulation reduced the potential bias that exists with the use of a single coder conducting data analysis, and it allows for increased reliability and validity of the data to be obtained (Creswell, 1998; Patton, 1999). Triangulation allows for the consideration of multiple perspectives and alternative explanations during the coding process (Creswell, 1998; Patton, 1999). The ultimate goal

in qualitative data analysis with a validation team is to reach consensual validity, or mutual agreement, to reflect the most salient results and interpretations of data derived. Emphatic neutrality also existed in the analysis of the data in this study. Emphatic neutrality is a "paradoxical stance in which the researcher is perceived as caring about and being interested in the people under study, but as being neutral about the findings" (Patton, 1999, p. 1204). The researcher of this study both cares and shows interest in the people investigated in this study, but acknowledges and embraces a neutral stance in reference to the findings.

Chapter 4: Results

Spiritual Experience Index-Revised

Each participant in this study completed the SEI-R. The group average for the SS scale was 57, and the group average for the SO scale was 38; this is reflective of a distribution of scores specific to this sample. "High" scorers were reflective of individual scores that fell above the group mean, and "low" scorers were indicative of individual scores that fell below the group mean.

One participant received low scores on both the SS and SO subscales and was classified as "underdeveloped." Underdeveloped individuals were defined as those who are spiritually disconnected, uncommitted, or lacking spiritual rootedness (Genia, 1997). Four participants received high scores on the SS subscale and low scores on the SO subscale; they were categorized as "dogmatic." Dogmatic individuals were defined as those who were confident in their spiritual convictions and formulations (Genia, 1997). Individuals in this category form strong attachments to their faith and identify strongly with its teachings and standards. Many religious persons stop spiritual development at this stage (Genia, 1997). The third grouping included participants who scored low on the SS subscale and high on the SO subscale, classifying them as "transitional;" two participants received this categorization. Transitional individuals were defined as those who were in a transitional period, reexamining their beliefs and ideals (Genia, 1997). These individuals may have held an unquestioning devotion to their spiritual community while in the dogmatic stage, but now are becoming more curious about different religious faiths and skeptical about previously held spiritual beliefs (Genia, 1997).

The final stage represented the most developed phase and included six

participants who received high scores on both the SS and SO subscales, classifying them as "growth-oriented." Growth-oriented individuals were defined as those who were strong in their spiritual convictions while simultaneously having a high tolerance for a variety of beliefs (Genia, 1997). In this stage, an individual has completed his or her religious exploration and has committed to a particular spiritual belief system, but remains eager for interfaith encounters and dialogue (Genia, 1997). A common developmental sequence of these four stages begins with an individual being underdeveloped, progressing through to dogmatic and transitional stages, and then to the more evolved growth-oriented stage (Genia, 1997). Table 2 illustrates SEI-R results.

Table 2

Spiritual Experience Index-Revised Scores

Participant	Spiritual Support Scale Score	Spiritual Openness Scale	Category
1A	60	39	Growth-Oriented
2B	57	38	Growth-Oriented
3C	60	32	Dogmatic
4D	60	28	Dogmatic
5E	54	41	Transitional
6F	60	34	Dogmatic
7G	50	39	Transitional
8H	59	47	Growth-Oriented
9I	59	39	Growth-Oriented
10J	57	37	Dogmatic
11K	59	44	Growth-Oriented
12L	56	37	Under-Developed
13M	57	40	Growth-Oriented
Group Average	57	38	Group Average

Emergent Themes

The findings of this study emerged from the transcribed narratives of the semi-structured interview questions. Three themes emerged from the transcripts in an attempt to synthesize the quantity and quality of data that were obtained. The three themes derived from the data analysis were perceptions of mental health and mental illness; perceptions of healing, treatment, and etiology; and referral practices and perceptions of community experiences. Table 3 contains an outline of descriptive findings, including themes and categories. Some quotes from participant interviews are included to help further refine and clarify the findings.

Table 3

Themes, Categories, Subcategories

Theme 1: Perceptions of Mental Health and Mental Illness	**Theme 2: Perceptions of Healing, Treatment, and Etiology**	**Theme 3: Referral Practices and Perceptions of Community Experiences**
Category 1: Beliefs and Perspectives ***Category 2:*** Levels of Awareness	***Category 1:*** Spiritual Problem Spiritual Solution ***Category 2:*** Mental Problem; Spiritual Solution ***Category 3:*** Spiritual and Mental Problem; Spiritual and Mental Solution	***Category 1:*** The "Why" (Reasons to Refer) ***Category 2:*** The "Who" (Would/Do They Refer) ***Category 3:*** Community Experiences

Perceptions of mental health and mental illness. The first theme that emerged was perceptions of mental health and mental illness. This theme describes African American clergy members' understanding, perceptions, and interpretations of mental health and mental illness; specifically, how mental health and illness are viewed and described.

Beliefs and perspectives. Clergy provided neutral, positive, and negative descriptors, along with behavioral indicators for someone they might view as mentally ill or mentally healthy. Clergy members focused on the multifaceted, multidimensional components that comprise mental health, including physical health, one's cognitive abilities, verbal capacities, and emotional healthiness. For example, Participant 1A described mental healthiness as "one's ability to rationally navigate through life, to make rational decisions, well thought out decisions, and be clear as to what their thought processes are, to communicate them physically, verbally, emotionally; so good mental health is the ability to do those things." Another participant focused on multiple facets of healthiness in her description of mental health:

> Mental health is the state of being that addresses your, um, psyche, the part of your being that involves your psychological state. At the same time, I believe that many things influence that so it's hard to separate. I believe emotional health, spiritual health, are also related to mental health and in some cases physical health. (Participant 10J)

Conversely, mental illness was described by Participant 6F as ". . . someone with a brain defect, or it doesn't work properly, or normally, compared to the average human." He used words like "average" and "normal" to foster the comparison between someone

viewed as healthy and unhealthy, assuming that one who is healthy is "normal" and one who is unhealthy could be viewed as "abnormal." He elaborated and further described how the norms that we use to place someone into an illness category is prescribed by others, "because our norms are prescribed by people. So, wow, that's hard because it almost kind of puts you into like a bullying mindset. Because either you conform to this one way or you're, you're mentally ill."

Mental illness was also viewed as stemming from a chemical imbalance or a brain defect. For example, Participant 1A described the cause of mental illness as a "chemical imbalance in the brain," further explaining that the chemical imbalance results from "poor nutrition." This view of mental illness is especially important because it strays from the original Pentecostal belief that mental illness is caused by spiritual factors alone. To acknowledge that those who are mentally ill may have chemical imbalances in the brain may increase the likelihood that they will receive and pursue help by mental health professionals, as well as accept psychotropic medications that can change the neurochemistry of the brain.

These various views acknowledge the complex, multifaceted nature of mental illness. There was a consensus that there are many factors, both external and internal, that influence mental illness. Some of the participants posited a holistic understanding of mental health and illness by describing the combination of emotional, spiritual, mental, and physical health as influencing one's mental state. This understanding of mental illness alludes to a combination of healing approaches in order to treat mental illness, as it was believed by many participants that there are a variety of factors that contribute to mental illness. This category highlights that there is no universal definition or

understanding within this community about mental health and illness; but that there are common factors that are recognized as contributory and associated with its development.

Levels of awareness. The second emergent category within the first theme was levels of awareness, which includes both conscious and unconscious processes. Clergy members described conscious and unconscious processes that occur within the African American religious community, including denial of problems, being unlikely to discuss mental illness, fear of judgment, increased awareness, admission, and, finally, acceptance. Clergy members acknowledged that both clergy members and patient-parishioners often deny mental health problems or avoid discussing mental health problems within the Church. They describe the fear of being viewed and judged as less spiritual or weak, and noted that vulnerability is stigmatizing:

> I think it's about admitting weakness as opposed to anything else. Particularly when it comes to men, they don't want to admit that there's a weakness. That there's a weakness, that there's a need, and that a White professional would be the only person that could help them, or a woman. (Participant 2B)

Some also endorsed the underlying view that "the man is out to get me:"

> . . . In my opinion, it might be predominately within the Black community because they still have that kind of mentality of thinking that the "man" is out to get me; and plus you have the ones that are for lack of a better word, "super-spiritual" and believe that whatever I have God can deal with it." (Participant 3C)

Many clergy members also highlighted how increased exposure from personal encounters, interactions with those who are mentally ill, and increased education about mental illness has led to an increased awareness and progression of their views of those

suffering with mental illness. For example, Participant 1A explained, "You see more, know more, you become more educated." Some acknowledged that this is also resultant from progression of views within the Church over the years, and that "30 or 40 years ago I wouldn't be having this conversation" (Participant 3C). There was a difference noted between admission of problems and acceptance of help. It appears that simply admitting one suffers from mental illness does not directly correlate to accepting and seeking help.

Clergy members described how the stigma that exists within the African American community is resultant from historical factors that are entrenched in the psyche of this community. Nevertheless, many acknowledged that there is a need for increased awareness of mental health concerns within both African American and religious communities. Clergy referred to having "eye opening" experiences or processes of "raised awareness." The use of the words "eye opening" and "raised awareness" not only acknowledge that there needs to be a conscious awareness raised, but also unconsciously, African Americans remain avoidant.

Describing denial as an unconscious process suggests that these behaviors are not under conscious control, and many clergy members and patient-parishioners may, therefore, be unaware of the severity of their mental illnesses. Additionally, this process is considered unconscious because it is ingrained both culturally and historically in the minds of many African Americans. This may be why clergy members consistently referenced an educative process that needs to occur in order to increase awareness and demystify the notion of mental health and illness. It appeared that those who encountered mental illness within their families or had personal encounters through their profession more readily acknowledged the pervasiveness, prevalence, and severity of mental health

concerns within their congregants. Due to the limited discourse that occurs within the Church about mental health and mental illness, the acknowledgement of mental illness is lacking, but it becomes difficult to ignore or deny discussions about mental illness when clergy are personally affected outside of their role as clergy.

Perceptions of healing, treatment, and etiology. Participants described multiple approaches to healing and treatment that were used consistently by these clergy members with their patient-parishioners or perceived to be used by outside practitioners with their patient-parishioners. Clergy approaches that were referenced consistently could be described as aspects of pastoral counseling. These included prayer, the use of scriptures for guidance, history gathering, love, patience, and enlisting social supports. Still, additional beliefs about the treatment of mental illness described the use of others by God for healing. Within this belief, psychologists and psychiatrists are used by God to heal through methods of consultation, therapy, and prescribing psychotropic medications. The final approach to healing was from God directly by miracles or miraculous healing.

Sullivan et al. (2014) presented three perspectives that are commonly held beliefs within clergy: (a) mental illness is a spiritual problem with a spiritual solution, (b) mental illness is a mental problem with a spiritual solution, and (c) mental illness is a mental problem with both a spiritual and mental solution. This researcher used two of Sullivan's categories to describe clergy members' perceptions of healing, treatment, and the understanding of the etiological underpinnings of illness. Those categories were spiritual problem/spiritual solution, and mental problem/spiritual solution. This researcher proposed an additional category, which was spiritual and mental problem/spiritual and mental solution.

Spiritual problem, spiritual solution. The clergy members who endorsed this perspective were skeptical of the existence of mental illness. They viewed both mental and emotional problems primarily as spiritual concerns. Some clergy members referred to sin as an explanation for someone suffering mentally. For example, Participant 6F explained, "I think the mental ill is in the same category as a person that's struggling from sin." Others reverted to beliefs about demonic possession as an explanation:

> . . . he had legions, he had all these demonic forces controlling his mind and body, and he said what is your name, and he said my name is "Legion." And the first thing Jesus did, he confronted that spirit. So a lot of times it takes the power of God to transform lives. (Participant 5E)

Those who only relied on spiritual explanations of mental illness relied solely on spiritual solutions for healing. Participant 5E endorsed the belief that "it takes the power of God," suggesting that only God can heal those who are suffering mentally. Clergy members who endorsed demonic possession as the primary cause of mental illness may be less likely to refer patient-parishioners to mental health professionals, because they may be more likely to rely solely on prayer, faith in God, miracles, exorcism, or some form of supernatural healing power to deliver.

Mental problem, spiritual solution. This perspective posits that mental illness and emotional problems are real, but that they are solved primarily through spiritual solutions (Sullivan et al., 2014). Those within this category provided the spiritual approaches to healing listed above, in addition to features associated with pastoral counseling. Those within this category discussed the combination of the supernatural healing power of deliverance with counseling approaches to treat mental illness:

> I think it happens just like anybody else that may need deliverance or healing. Any type of help from the Lord. I think it is a matter of praying and waiting for the Lord to respond. Consistent prayer, consistent fasting, and lifting that person up in the name of Jesus I think can heal any and all situations (Participant 6F)

> I think the most important thing is to be, to have a good ear, and listen to people, and help them talk. Because most of the time when they talk they'll solve their own problems. But the problem is they feel bound, they feel like they can't express themselves because of what people are going to think or how they are going to be perceived. So that's how I've treated it, by listening to people. (Participant 8H)

Prayer, history gathering, and the use of scriptures were often reported as used in tandem with one another. This included first gaining an understanding of the problem, then applying scriptures as a source of encouragement and guidance, and finally praying for God to heal and deliver. This is similar to how Kramer et al. (2007), described how a clergy member decides if the parishioner needs to "heal the soul" through spiritual approaches like prayer, worship, or scripture (p. 133). The use of love and patience was referenced throughout the interviews. Due to patient-parishioners' lack of follow-through on the advice or counsel provided to them by clergy members, love and patience were recommended as necessary traits to have when working with parishioners. Love and patience are characteristics that God has shown toward His people and, therefore, many clergy members described displaying the same love and patience for others. Finally, enlisting social supports was a form of treatment that was used, due to the

understanding that loved ones provide a level of "healing" that can take place outside of the church and, instead, in the home.

Spiritual and mental problem, spiritual and mental solution. Clergy members who endorsed beliefs from this perspective viewed mental illness as real, and believed that patient-parishioners would benefit from a combined approach to treatment and healing, combining components of supernatural healing and deliverance, pastoral counseling, and formal mental health services. Those in this category acknowledged the benefits of the combined spiritual components with medication and/or psychotherapy. Out of each category, those with this perspective may be more likely to refer to mental health providers given their beliefs about the etiology of mental illness.

Clergy members who fell into this category acknowledged the Biblical and genetic basis of mental illness. In acknowledging the notion that scriptures refer to people as "born in sin" and that this is perpetuated throughout generations, Participant 9I noted that mental illness can also be inherited generationally. Other participants referenced the combination of mental health professionals and God as an effective way to receive both healing and treatment. Participant 4D emphasized how some clergy will just want to pray, which functions as a temporary cure for mental illness, as healing needs to occur from "the inside out." Clergy referred to the function of psychologists and psychiatrists as taking healing a step further than spiritual healing. These participants expressed that God can heal supernaturally and miraculously, but that, at times, prescriptions and therapy are necessary. This view still credits God for the ultimate healing, but suggests that psychologists and psychiatrists are tools or instruments used by God to provide the entire manifestation of one's healing.

Those with this perspective were more likely to endorse a more holistic approach to mental health treatment, acknowledging that Christ himself was a "holistic person." A holistic approach to treatment considers the physical, mental, spiritual, and emotional health of the patient-parishioner. In order to receive total healing, one would need to receive healing in all of those areas in combination:

> . . . because for me there is a level of spiritual imbalance because everything from my understanding is spiritual and then physical. But on the realistic end of things you have to look at the natural, you cannot ignore that, so you also have to be able to address them on the natural level . . . There are cases in the scripture where people had issues and because of the spiritual end Jesus and the religious leaders of those days dealt with the spiritual piece, but also said, well okay, you need to go wash, or you need to go clean, or clean your eyes, go wash yourself to the priest. It was the physical thing they also had them to do, so they addressed the spiritual but they also dealt with the natural. (Participant 1A)

For another participant, holistic healing also included incorporating social justice into aspects of treatment: "I think the Church sometimes is contained to this, deliverance, healing, and that's it. You know, where as though the Church for me is something that, it should address everything; like, social injustice, uh, politics, it's supposed to address all of that" (Participant 6F). This echoes the roles and the function of the Black Church when it was first formed. This view suggests that the function of the Pentecostal Black Church has evolved into only focusing on "healing and deliverance" at the expense of ignoring congregants' other needs.

Whereas some clergy viewed a spiritual solution and some viewed a combined spiritual and mental solution to healing mental illness, still others acknowledged, albeit uncomfortably, that some never receive healing: "I believe some people get healed and some people don't. I really do. I believe that you can be a Christian, you can be born again, blood washed believer, and still struggle with mental illness" (Participant 8H). Although patient-parishioners seek and receive treatment, not all are receiving healing. Clergy members believed that God can heal and that there are multiple factors that cause mental illness; however, still some, despite best efforts, do not receive healing. This could be as a result of the perceived causes of mental illness. For instance, if an individual believes that mental illness is also caused by chemical imbalances, he or she may be more willing to accept that God cannot heal; however, if he or she attributes primarily spiritual causes to mental illness, he or she may be less willing to accept that God cannot heal.

Despite previously suggested beliefs about Pentecostal clergy, in this study, not all were attributing lack of faith to reasons why some are not healed. Instead, some stated that God is choosing not to heal: ". . . in the Church we are taught, and the Bible says that Jesus can heal it all. And I'm not saying Jesus can't heal it all, he can heal it all, but he doesn't always do it" (Participant 2B). Another participant explained that "believing that God is all-powerful, but 'not involved' is scary. Because all your life it's been like, God can do it. And not saying that he can't, but in that moment, forgive me Lord, he couldn't. I'm going to have to repent for my sins after this" (Participant 6F). This appeared particularly difficult for clergy members to discuss and express, as it could be perceived or interpreted as they were lacking of faith in God. Clergy members seemed to endorse

the belief that even if a parishioner renounces his or her sin, increases faith in God, and seeks spiritual and/or secular counseling, that God is sovereign and will do whatever He wills to do, as God. Clergy were unable to explain why God chooses to heal some and not others. Nevertheless, they still found solace and comfort in their faith and trust in God for healing to eventually occur. Many found consolation in the belief that if healing does not take place on Earth, healing will occur once the "Earthly bodies" have been transformed in Heaven.

Referral practices and perceptions of community experiences. The final theme that emerged was referral practices and perceptions of community experiences. This theme explored how clergy members have perceived their interactions with community mental health providers and their preferred referral practices. Reasons that clergy members refer to mental health professionals were identified.

Reasons to refer. Clergy members explored reasons why they would refer to mental health professionals. Among these included perceived lack of training, the severity of the psychiatric symptomatology, and for the patient-parishioner to receive professional care. Every clergy member stated that he or she would refer to mental health services, but not everyone has, despite all interviewees having indicated that they have encountered individuals with mental illness. Interviewees provided descriptions of lacking in training including feeling ill equipped, that the situation was "above my paygrade," or certain things are not "within the scope of my practice." Suicide was consistently referenced as severe enough to warrant a referral to a mental health professional. Clergy members felt comfortable stating that they would refer to mental

health professionals who are "trained and licensed" to handle suicidal patient-parishioners:

> Refer people yes, they never follow through. They were reluctant and most of them didn't believe they had a problem. Um, they were in denial, the majority of them are in denial . . . Getting people treatment and help because it's frowned upon, it's looked down upon and it's not respected. (Participant 4D)

> Referring to the hypothetical situation: But with a statement like that, the last statement, and I know that we are really teetering on the side of suicidal ideation and we could not take that as just everybody start praying, although we would be, that's not enough. And so we would have to, I would probably call the counseling service that we refer people to and I would explain, give the same scenario, and ask them how they would suggest that we respond. I would be seriously considering whether or not we needed to have some discussion about 302 because obviously this is a crisis situation. (Participant 10J)

Denial is referenced as a barrier to patient-parishioners receiving help, even when they have been referred. Suicide was described consistently as something that clergy members felt unprepared to handle due to the severity of the symptomatology and the lethality that accompanies suicide. This confirms what research suggests, that clergy members also experience patient-parishioners who have the same severity as those receiving mental health services within the community.

Referring parishioners for mental health treatment. Clergy members described to whom they would feel and have felt most comfortable referring parishioners. Among

those identified were Christian mental health providers and trusted established providers. Surprisingly, for the African American clergy interviewed in this study, it was more important for the therapist to identify as Christian than to identify as African American. Clergy members felt more comfortable referring patient-parishioners to Christian mental health providers regardless of their identified race or ethnicity. Clergy explained consistently how Christian mental health providers share the same beliefs, and they will not have to fear that they will be misled or receive misinformation:

> I would rather if my child has a psychiatric issue, I would rather go to a Christian psychiatrist, I really would, because we have similar beliefs, but oftentimes because we don't know those resources or we don't have them in the church we are going out to secular people and they have different views. Their backgrounds are different; their perspectives are different. (Participant 8H)

As African American clergy members, their identities as clergy appeared to be more significant and impacting of their referral practices than their racial and cultural identification. As clergy members, they are responsible for their parishioners and they want to make sure that they are not receiving information that is contrary to their religious beliefs and the Bible. Sharing similar religious beliefs was more important than sharing similar racial backgrounds or beliefs. For the clergy in this study, more emphasis was placed on religion and less on race as it pertains to referring their parishioners, which may highlight that for clergy, being a clergy member is the primary identity, and race may be a secondary identity.

Perceptions of community experiences. Clergy members described having mixed and/or negative experiences with mental health providers. Some remained hopeful

for future collaborative interactions with mental health professionals. There appeared to be consistency among clergy regarding reasons to refer, but a considerable decline in those who actually do. As a result, many clergy members did not have community experiences to refer to but were able to suggest collaboration in the future:

> So having mental illness or whatever you call it, mental professionals, as well as clergy members working together united would help the overall body, mind, and soul of the clergy people is my opinion. Working as a unit, working together. Not against each other but together in the treatment of whether you want to use the patient term, or clergy member, whichever term. I think it would be an eye opener and beneficial to a lot of clergymen and church members to get on board and maybe have a health fair and reach out and try and fix and bring everyone together within our African American community. You know, the Black race, whatever term you want to use. And just bring everybody together and be on the same page so people can get the help and care that they need. (Participant 4D)

> So I think my departing remarks would be that I hope that clergy everywhere would begin to marry or partner with the professionals so we could come up with a viable plan of attack, because I do think many people can be healed, many people can be cured, but not from either single side. (Participant 9I)

The clergy within this sample described the positive impact of uniting, as one would experience by engaging in healing of the overall mind and body of a patient-parishioner.

Chapter 5: Discussion

This qualitative study explored Pentecostal African American clergy members' perceptions of mental health and illness and the influence those perspectives have on subsequent referral practices. This study attempted to contribute to the literature by exploring the views African American clergy members have about mental health and mental illness by using a grounded theory of analysis, the outcomes of which provided evidence for three emerging themes. The themes included perceptions of mental health and mental illness; perceptions of healing, treatment, and etiology; and referral practices and perceptions of community experiences.

Different frameworks of the etiology of illness and subsequent approaches to healing can interfere with one's ability to seek help, which is worsened by the preexisting conflict that exists between clergy and mental health care providers (Sullivan et al., 2014). Comparably, clergy members who "demonize the biomedical model of mental health treatment" can also delay or interfere with one's desire to seek help (Sullivan et al., 2014, p. 1269). Those who endorse the perspective that mental illness is a spiritual problem with a spiritual solution view mental illness and psychological concerns as "manifestations of demon possession, evil spirits, or the work of the devil" (Sullivan et al., 2014, p. 1269). The clergy in this study who held this view may be less likely to actually refer to mental health professionals as a result of relying on prayer and faith in God to deliver and to heal. This was consistent with the results found by Sullivan et al. (2014), which indicated, "a cure may involve exorcism or faith healing" and that the "use of psychotherapy and medication demonstrates a lack of faith" (p.1276).

The view that mental illness is a mental problem with a spiritual solution is a part of the most widely held beliefs in faith communities (Sullivan et al., 2014). Fundamentally, within this view, mental illness is perceived as originating from a spiritual phenomenon, but at present, there is more acceptance that mental illness exists. Contrary to the findings of this current study, Sullivan et al. (2014) noted that mental illness is "less likely to be seen as a direct result of evil spirits or of the devil, but instead, as resulting from a loss of faith, lack of prayer, stress, and getting away from the Lord" (p. 1278). African American clergy within this study referred primarily to external and spiritual factors as the causes of mental illness. Consistent with Sullivan et al. was that clergy members in the current study did not view mental health professionals as "evil" but viewed them as necessary only in "extreme cases." Indeed, clergy members in this study reported that they would refer to mental health services if situations were extreme or if they felt ill equipped, but would prefer situations to be resolved through God or Biblical counseling first.

Although Sullivan et al. (2014) posited a category entitled, "mental problem, spiritual and mental solution," this researcher derived an alternate category that appeared more relevant to the study's sample. The final view endorsed was that mental illness was both a spiritual and mental problem, with a spiritual and mental solution. Those in this category acknowledge the benefit of the combined spiritual components with medication and/or psychotherapy. Mental illness stigma may be lower among those in this perspective, there may be less interference with seeking professional help from a mental health provider, and, in fact, help-seeking behaviors may be encouraged (Sullivan et al., 2014).

Patients who are also religiously committed are often wary of discussing psychological problems with professionals who are not also religiously committed (Greenidge & Baker 2012). When religious patients seek counseling from secular providers, they often are still engaging in spiritual practices alongside their mental health treatment; ultimately, adhering to two parallel treatment models simultaneously (Greenidge & Baker 2012). Patient-parishioners may believe seeking counseling from secular providers may threaten or challenge their religious values. Sharing such intimate details about their spiritual values and beliefs and permitting "nonbelievers" to have access to this information may present tension to patient-parishioners. This may also decrease the likelihood that they would seek services even if they were in psychological distress. Consequently, these religious patients often prefer receiving treatment from Christian psychologists who are able to balance their spiritual and emotional needs simultaneously.

Clergy members in this study also preferred Christian mental health providers in lieu of secular mental health providers. As mentioned previously, as clergy, participants' primary focus was Christianity and their African American descent was secondary in considering to whom to refer their parishioners. There are many distinctions and much diversity within Christian counseling and Christian psychology, necessitating clarification to help determine how to refer someone to a mental health professional that will honor and respect the patient-parishioner's Christian values (McMinn, Staley, Webb, & Seegobin, 2010). Major approaches to Christian counseling include Biblical counseling, pastoral counseling, Christian psychology, and Christian ministry (McMinn

et al., 2010). For the purposes of this review, Christian psychology will receive the focus.

The concept of a Christian psychologist consists of two meanings. The first interpretation refers to Christians who are trained as psychologists and are willing to identify and use their faith as an integral component of their clinical work (McMinn et al., 2010). These psychologists are called integrationists, due to their integration of religious and spiritual knowledge with psychological principles and interventions (McMinn et al., 2010). Integrationists often value both professional psychology and Christianity and, therefore, seek to connect their psychotherapeutic intervention and skills to their Christian values (McMinn et al., 2010). They reflect on and observe two perspectives simultaneously, the psychological and the religious (McMinn et al., 2010). Consequently, they explore both psychological and spiritual aspects of the patient's presentation and seek to unite both in their treatment efforts. The second interpretation of Christian psychologists are those philosophers and mental health professionals who belong to the Society of Christian Psychology (SCP). Members of this society use the wisdom derived from the Bible and other Christian texts to inform their psychological treatment and practice (McMinn et al., 2010). Typically, when one is considering referring to a Christian psychologist, integrationists are in mind.

Research has shown that integrating spiritual and religious beliefs into therapy can be as effective, if not more effective, in reducing symptomatology in religious clients (Pearce & Koenig, 2013). Christian cognitive behavioral therapy (C-CBT) is an integrative approach to therapy that incorporates spiritual and religious components into traditional CBT approaches (Pearce & Koenig, 2013). These components may include

the use of Biblical scriptures, religious imagery, spiritual coping, meditative prayer, and Christian theology. Ultimately, practitioners from this framework use the patient-parishioner's Christian faith as a foundation to identify, challenge, and restructure maladaptive thoughts, emphasizing spiritual practices as a way to aid the restructuring process (Pearce & Koenig, 2013). For instance, scriptures may help the patient-parishioner develop more adaptive ways of thinking, informed by Biblical themes and teachings; however, with this approach, the clinician should remain culturally informed about the appropriate use of scriptures within the correct context (Pearce & Koenig, 2013).

C-CBT can be beneficial for African American patient-parishioners in five ways. First, C-CBT is a framework that encourages positive thinking and behaviors, which, in turn, promotes a sense of meaning and purpose (Pearce & Koenig, 2013). Second, within C-CBT, patient-parishioners begin to focus on the needs of others through acts of gratitude and generosity, which may help to counteract feelings of depression and, again, create a sense of meaning and purpose (Pearce & Koenig, 2013). Patient-parishioners are reminded of the Biblical verse, "Do unto others as you would have them do unto you," which can increase behavioral activation and active coping with distress. Thanking God for all of the things that He has done can instill feelings of gratitude and thankfulness, acknowledging that God cares for them, which may increase their motivation to persevere during moments of distress (Pearce & Koenig, 2013).

Third, C-CBT can improve overall depressive symptoms and physical health outcomes through challenging cognitive distortions that tend to be incongruent with Biblical teachings (Pearce & Koenig, 2013). Fourth, C-CBT promotes involvement in

spiritual practice within one's faith community, which increases one's social support and social network, while reducing isolation and avoidance (Pearce & Koenig, 2013). Finally, C-CBT may increase the client's overall outlook on life, acknowledging that although trials and tribulations occur, the patient-parishioner's belief in a God who is a deliverer, a healer, and everything that they may need (Pearce & Koenig, 2013). This produces a stronger therapeutic alliance and may improve overall psychological functioning (Pearce & Koenig, 2013).

Of note, incorporated in religious cultural competence is the understanding that there may be nuances to Christian religious beliefs and practices, interpretation of scripture, and the degree to which patient-parishioners would like their faith incorporated into their treatment (Pearce & Koenig, 2013). In order to practice competently, it is vital that clinicians explore patient-parishioners' religious and spiritual histories, the relevance and importance of religion in their daily functioning, and the ways in which religion can be incorporated into their psychological treatment (Pearce & Koenig, 2013). Christianity teaches generosity, benevolence, and forgiveness, which can be included in understanding the patient-parishioners current level of distress and scriptural verses, which may be memorized in order to provide encouragement and lead them back to a healthy mindset (Pearce & Koenig, 2013). C-CBT differs from pastoral counseling approaches, in that the primary focus in C-CBT is the patient-parishioner's mental health, whereas in pastoral counseling, the focus is on the patient-parishioner's spiritual health (Pearce & Koenig, 2013).

C-CBT may be particularly effective within the African American Christian population. As mentioned, African American Christians who seek mental health

treatment are typically adhering to two treatment models simultaneously. The use of Christian cognitive approaches may increase overall treatment effectiveness and service utilization if Christian tenets and principles can be incorporated into treatment. The hesitancy that African American Christians experience with being treated by "secular" mental health providers may be reduced if secular mental health providers integrate religious beliefs and aspects into the interventions provided. Not only can this work to build the therapeutic relationship and decrease the stigma associated with receiving services, but it may also increase the overall satisfaction of receiving these services.

C-CBT promotes involvement in spiritual practice within one's faith community, which is particularly advantageous for a community of people who identify with their Christian identity. Incorporating their social networks and spiritual supports may assist in bridging the gap between spiritual and mental health providers, while also fostering collaboration, relationships, and community. This approach can work toward reducing the stigma and taboo associated with receiving mental health services and begin to validate past experiences of institutionalized racism and health disparities experienced by this community. This may encourage a stronger therapeutic relationship and improve overall spiritual and psychological functioning of African Americans.

Ultimately, clinicians should be aware and knowledgeable about the nuances of Christian counseling and psychology, as referrals to this specialty can help bridge the gap between the religious African American community and mental health treatment providers. As a client presents to treatment and begins to seek Christian guidance and counseling, it is good practice to clarify exactly what they are expecting from a psychologist. Patient-parishioners may be looking for a Christian who is also a

psychologist because they prefer someone to understand their perspective. They may be looking for a psychologist who is open to incorporating spirituality and spiritual interventions into treatment, while respecting Christian beliefs. This person may or may not be a self-identified Christian, but is knowledgeable and respectful of religious tenets (McMinn et al., 2010).

Mental health practitioners have the responsibility to emphasize the spiritual beliefs and practices of patient-parishioners as they present for treatment (Sullivan et al., 2014). The biopsychosocial-spiritual model provides a structure for the integration of spirituality into clinical practice (Brown, Elkonin, & Naicker, 2013). This model encourages clinicians to consider the role that religion and spirituality has on the lives of their patients. This model posits that psychological illnesses develop from an interactive and evolved process that incorporates genetic, biological, psychological, emotional, behavioral, cognitive, social, and familial factors while acknowledging the simultaneous impact that spirituality has on the development, recovery, and protection against mental illness (Brown et al., 2013). There are psychological aspects that have been identified in religion and spirituality, including lifespan development, social psychological phenomenon of group dynamics, affective and emotional states that are elicited through the practice of religion, and the influences of religion and spirituality on personality development. Psychologists are beginning to realize that religion and spirituality play an integral role in the psychological functioning of their patients (Brown et al., 2013).

Limitations of the Current Study

There are multiple factors present within this study that may limit the transferability and generalizability beyond the population included in this study. First,

the sample size was small. Consequently, this places limits on the generalizability to the population at large, and results concluded in this study may not generalize across other races or denominations. Second, subjects self-selected to participate in this study and the results were self-reported. Self-selection eliminates a population of clergy members who did not select to participate and the information that may have been gleaned about their rationale for not participating and any additional information they could provide about the topic. Additionally, the clergy members' self-reports may have been impacted by factors such as social desirability or limited by factors such as defensive reactions to the topic.

A third limitation is that the researcher did not perform initial coding for every transcript, and instead only performed it on the initial diverse set of four. This may have placed a limitation on the degree of theoretical saturation that could be obtained. Finally, researcher bias or expectancy effects may have unintentionally shaped the way the analyses were performed. Included in this is the perspective of the researcher. In qualitative research, it is recommended that the researcher explicitly state his or her perspectives about the construct of interest and phenomenon being studied. Additionally, the person-of-the-therapist model emphasized the importance of increased self-awareness in consideration of one's personal history and how that influences one's perception of the phenomenon being studied (Aponte & Winter, 1987). The concept is to report any personal or professional information that may have affected the collection of data, data analysis, or interpretation of the research findings (Patton, 1999).

The researcher's perspective is considered in the following statements. This researcher believes that God in addition to mental health services can "heal" and treat

someone with mental health concerns. The researcher believes that faith in God in collaboration with mental health services will increase the likelihood that the person will be truly healed. Additionally, this researcher conducted this study as a result of being of a Pentecostal background, and believing in the Pentecostal tenets that were aforementioned. This could have led to biases that may have shaped the lens for the questions that were being asked and for the inclusion of a grounded theory approach in the first place.

Much like quantitative research, qualitative research may present with problems of internal validity, consensual validity, and interrater reliability. Efforts were made to increase the credibility, validity, and interrater reliability, while decreasing subjectivity within the data analysis by using a validation team. Nevertheless, those methods employed may not eliminate researcher bias fully. The use of the validation team to establish consensual validity with the themes, categories, and subcategories that emerged was implemented to address the influence of researcher bias. Because of this bias and the potential concerns that it may have presented with validity, a validation team was used to assist in analysis of the data to minimize the subjective bias of the researcher.

Future Research and Clinical Implications

The study sought to explore the interactions between African American clergy members and their subsequent referral practices to mental health services. One future goal for the collaboration between religion and psychology is to allow mental health professionals the ability to reach out to trusted sources in the community in order to reduce the stigma and mistrust that is associated with seeking mental health services. The Black Church is the ideal place to offer preventative care to patient-parishioners, as

this is typically the front-line and most frequently visited place for African Americans suffering with mental illness (Hedman, 2014).

Another goal is to increase the subsequent referral practices that are followed through by African American clergy members, in an effort to increase collaboration and bridge the gap between the disciplines. Providing psychoeducation to clergy members to increase their knowledge and awareness about mental illness, prevention, and treatment options could benefit their communities and decrease the stigma related to help-seeking behaviors (Hedman, 2014). Additionally, it may be helpful to gain an understanding of patient-parishioners' perspectives of mental health and mental illness.

Once the referral to mental health services takes place, the goal is for the treating mental health professional to become educated about the religious implications within their therapeutic relationship. Specifically, mental health professionals should seek to understand the religious identities of clients in an effort to incorporate religion and spirituality into treatment as appropriate. Education on cultural competence and cultural sensitivity is essential for mental health treatment providers to offer a variety of effective treatment options to African Americans that are consistent and support their cultural values and religious beliefs (Cai & Robst, 2016). Mental health providers could find a way to incorporate spiritual components into their treatment. Kramer et al. (2007) suggested that a CBT approach that incorporates religious guided imagery or religious affirmations was shown to be more effective with patient-parishioners than standard CBT alone.

Although both spiritual and mental health care are effective when treating patient-parishioners, a blend of many approaches incorporating spiritual, psychological, social,

and biological components would offer treatment in a more holistic manner. Research on the reduction of stigma shows that interventions aimed at direct contact was the "most effective method for reducing general population stigma" (Sullivan et al., 2014, p. 1278). Therefore, Sullivan et al. (2014) suggested mental health professionals and clergy combining to collaborate on community events that are aimed at reducing stigma and building trust within African American patient-parishioners.

The Black Church can function as a vital source of support in increasing the help-seeking behaviors within their patient-parishioners and increasing their abilities to access and utilize mental health services as needed. Clergy members can represent a "cultural bridge between the formal healthcare system and recipients of care" but they often lack the official training and coursework needed to accurately identify and notice mental health conditions that arise in their congregations (Kramer et al., 2007, p. 124). Additionally, mental health providers often lack the training and knowledge-base to fully address the spiritual needs of their patients (Sullivan et al., 2014). The history between clergy and mental health professionals can be described as conflictual, controversial, and contentious. Clinicians and clergy members who seek to holistically treat the needs of African American patient-parishioners must not only be aware, but also acknowledge this complex relationship as a working relationship that is essential for meeting the needs of the African American patient-parishioner community. For the aforementioned reasons, collaboration between clergy and mental health providers is a natural strategy and of paramount importance.

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Appendix A

Recruitment E-mail

Dear Potential Participant,

My name is Jasmine Harris and currently, I am a 4th year student in the Clinical Psychology Doctoral Program at Philadelphia College of Osteopathic Medicine. One of the last components of my program before I can officially become Dr. Harris, is my dissertation. I am currently working on a research study with my professor Dr. Thompson exploring the connections between psychology and religion. I write to you because I am looking for African American Pentecostal Clergy Members who could potentially assist me with my study exploring perceptions that people have of mental health. Participation in this study is completely voluntary, and if you qualify to participate I can discuss this study with you via telephone. If you choose to participate, we can either meet in person or over the telephone at your convenience. If you would like to join this study, please reply to this email with a telephone number and a convenient time for me to call you and discuss this study further. Thank you very much for your time.

Appendix B

Demographic Questionnaire

Please answer the questions below by marking **one** line

1. Gender: 01) Male _____ 02) Female_____

2. Years of age: _____

3. What is your identified race/ethnicity?

_____ 01) African American _____04) American Indian/Alaskan Native

_____02) Caucasian _____05) Asian/Pacific Islander

_____03) Hispanic/Latino _____ 06) Bi-Racial

4. Highest level of Education

_____ 01) Less than 12th grade _____05) Master's Degree

_____02) High School Graduate/GED _____ 06) Doctoral Degree

_____03) Associates Degree/some college _____ 07) Other

_____04) Bachelor's Degree

5. Have you obtained any degrees specific to ministry? Licenses? Certificates?

_____

6. How long have you been a Christian?

_____

7. How long have you been a clergy member?

_____

8. What education is expected of you to be a clergy member?

_____

9. What denomination were you raised under?

_____

10. Have you ever been a member of a church denomination other than Pentecostalism?

_____

11. If yes to #10, please indicate which denomination(s), and how many years

_____

12. How many ears have you been a member at this church?

_____

13. How many years have you been a clergy member at this church?

_____

14. Which roles have you occupied within this church and for how long?

_____

15. Have you referred members to mental health counseling?

_____

16. Have you directly or indirectly been exposed to individuals suffering from mental illness?

_____

Appendix C

Semi-Structured Interview Questions

1. Could you provide me with your own definition of mental health? What would you term the opposite of mental health? Can you provide me with that definition as well?
2. What are your views of mental health concerns (whatever word they choose from question one)? of mental health? Where did these views come from?
3. What has been your experience of treating Mental Health in your church?
4. Have you encountered a scenario involving mental health concerns that you did not feel well-equipped to handle? What did you do?
5. What are your beliefs about treating mental health concerns? How does one receive healing?
6. How does your belief in God influence your perception of Mental health concerns?
7. What kinds of mental health problems have you encountered? What did you do?
8. What kinds of spiritual advice/counsel have you given those who were suffering mentally?
9. What are your referral practices? Do you solve things in house? Have you referred elsewhere before?
10. Hypothetically speaking, someone comes to you with depression, anxiety, psychosis, substance abuse…what do you do?
11. As a clergy member, what is the most challenging part for you in attending to the mental health concerns of the congregation
12. What are you positive and negative experiences with mental health care providers in your community?
13. How often do you talk about mental health issues with other clergy?
14. Are you aware of any mental health treatment providers within your congregation?
15. Is there anything you would like to tell me about this topic that I didn't ask?

Appendix D

Hypothetical Situation

John West is a 55-year-old African American male member of your church. He has been married for the past 31 years to his wife, Sarah, and from their union they have a 25-year-old daughter. John has been behaving differently at church and at home. John was employed as a construction worker for 30 years, and was recently let go from his job due to down-sizing within the organization. Ever since John has been let go, he has been behaving differently at home and at church. He was a zealous member of the deacon board and has since resigned, citing that the "deacon board deserves a more committed member, and I no longer have the energy." He has begun to miss Sunday morning services, and refuses to answer the phone when church members call to check in on him. At home he has become withdrawn and irritable towards his wife and daughter. His wife says that he has a difficult time sleeping and wakes up the next day fatigued. He has felt "sad and blue" more days than he has felt happy. He used to fish with his friends and has cancelled on them for the past 3 weeks in a row. The last time John came to church he mentioned that "life would be better if I was no longer around". How would you handle this situation?